CONSENT FOR ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

***** NON-PRESCRIPTION MEDICATION *****

VERNDALE PUBLIC SCHOOL

Student's Name: _____ Birthdate: _____

Parent's Name: _____ Primary Phone: _____

Home Address: _____ Secondary Phone: _____

****

Please administer the over-the-counter medication to my student as listed below:

Medication _____

Dosage _____

Time _____

Condition/Purpose _____

Possible Side Effects _____

Can Self-Administer (High School Only) _____ Yes _____ No

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PARENTAL RELEASE FOR ADMINISTRATION OF MEDICATION

I request that this medication be given to my student as directed above. I release any school personnel from liability in relation to the giving of this medication at school. I understand that this medication must be supplied to the school in its original, labeled container.

Parent/Guardian Signature _____ Date _____