



AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION AT SCHOOL
(additional non-prescription medications not listed on MRCA Student Medical Information form)

PLEASE PRINT School Year _____

STUDENT'S NAME _____ Homebase Teacher _____

NAME OF MEDICATION _____

REASON FOR GIVING MEDICATION AT SCHOOL (Please be specific):

DOSAGE/AMOUNT OF MEDICATION TO BE GIVEN _____

TIME OF DAY MEDICATION IS TO BE GIVEN AT SCHOOL _____

DATE TO START MEDICATION _____ DATE TO STOP MEDICATION _____

EXPIRATION DATE OF MEDICATION _____

POSSIBLE SIDE EFFECTS _____

Parents Please Read Carefully:

I understand that all medication will be provided by me in the original container, clearly labeled with my child's name. I will notify the school if the medication is discontinued or the dosage has been changed. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I am responsible for replacing medication before the expiration date. Expired medication will not be given at school.

PLEASE PRINT PARENT/LEGAL GUARDIAN NAME _____

PARENT/LEGAL GUARDIAN SIGNATURE _____ DATE _____

PLEASE NOTE:

A SEPARATE PERMISSION FORM IS REQUIRED FOR EACH MEDICATION TO BE GIVEN.

PLEASE PICK UP ALL MEDICATIONS PRIOR TO THE LAST DAY OF SCHOOL. ANY MEDICATION NOT PICKED UP WILL BE DESTROYED.

ALL MEDICATIONS MUST BE HAND DELIVERED BY AN ADULT TO THE SCHOOL NURSE OR MAIN RECEPTIONIST IF THE NURSE IS NOT AVAILABLE.