OKEMOS PUBLIC SCHOOLS

AUTHORIZATION FOR ADMINISTRATION OF
NON-PRESCRIPTION *MEDICATION*

Student Name ______________________________ Birth Date_______________ Grade___________	Teacher ______________________ School _______________________	Date form received _________

To be completed by a parent

Name of Medication ____

Reason for Medication ____

Instructions (schedule and dose to be given at school) ____________________________________

____

Anticipated Duration ____

The student is both capable and responsible for self-administering this medication:

__________ No __________ Yes, supervised __________ Yes, unsupervised

I give my permission for my child, _________________________________ , to carry the above medication with him/her during the school day. It is understood that the medication that is being carried cannot be shared with other students.

Please attach any additional information you feel necessary for the school to know regarding the administration of this medication.

Parent Consent:

I request that _______________________________________ receive the above medication at school according to the standard school policy.

I request that _______________________________________ be allowed to self administer the medication at school according to the school policy.

Date _________ Signature _________________________________ Relationship __________________

Phone #'s: Home ___________________ Work _________________ Emergency ___________________

I