School District of Bruce

Authorization for Medication Administration

Non-Prescription Medication

Student Name: _____ Date of Birth: _____

Grade: _____ Teacher (if in elementary school): _____

Medication Information & Instructions

Medication Name: _____

☐Tablet/Capsule ☐Liquid ☐Other_____

Dose & Frequency:_____

_____

☐ Use throughout school year 20____- 20____ **OR** ☐ Start date_____ End date _____

Reason for medication: _____

Parent/Guardian Signature

I understand the following:

- Medication must be in the original container with labels and instructions.
- Medication must be age appropriate for the student and not expired.
- Medication must be administered according to the manufacturer's instructions.
- Unused medication must be picked up from school at the end of the school year or it will be disposed of.
- New permission forms must be completed each school year and if there are changes in the medication or dose.

School personnel have my permission to administer this medication/treatment as indicated above. I agree to hold the school district, its employees or persons who are acting on this request, harmless in any and all claims arising from the administration of this medication/treatment at school and school events.

_____	_____	_____
Parent/Guardian Signature	Relationship to student	Date