

PARENT/GUARDIAN MUST SUPPLY MEDICATION IN AN ORIGINAL CONTAINER

PERMISSION FOR NON-PRESCRIPTION MEDICATIONS

Loudonville-Perrysville Schools
Authorization Form

Student: _____ Date of Birth: _____

Grade: _____ Homeroom Teacher: _____

NON-PRESCRIPTION MEDICATION-----TO BE COMPLETED BY PARENT/GUARDIAN

Reason for medication: _____

Name of medication: _____

Form of medication/treatment:

____ Tablet/capsule ____ liquid ____ Inhaler Other: _____ Dosage: _____

Instructions (Schedule and dose to be given at school): _____

Is this student both capable and responsible for self-administering this medication? _____

Comments: _____

I give permission for _____ to receive the above non-prescription medication at school according to the policy of the Loudonville-Perrysville Board of Education.

Parent/Guardian signature

Date

PERMISSION VOID AT END OF CURRENT SCHOOL YEAR

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