SCHOOL DISTRICT OF LADYSMITH
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

NON-PRESCRIPTION MEDICATION

Name of Student: ____Birthdate: _______________

Parent/Guardian: ____ Phone: ________________

Address: ____

School: _______________________________ Grade: _______Teacher: ________________

Part I - Parent's/Guardian's Statement

I hereby request the school to administer the following non-prescription medication. I further exonerate the School District of Ladysmith from any liability resulting there from.

1. Reason for medication ____
2. Name/type of medication ____
3. Dosage/amount to be given ____
4. Frequency/times to be administered ____
5. Duration (week, month, indefinite, etc.) ____

____

Parent's/Guardian's Signature Date Signed

Part II - Designated Person(s) Administering Drugs

I have agreed to administer the medication as requested by the parents/guardians and in accordance with directions listed above by the physician.

____

Signature of Person(s) Administering Medication Date Signed

IT IS THE POLICY OF THE SCHOOL DISTRICT OF LADYSMITH THAT MEDICATION BE BROUGHT TO THE SCHOOL IN THE ORIGINAL CONTAINER. ANY MEDICINE NOT IN THE ORIGINAL CONTAINER WILL NOT BE DISPENSED TO ANY STUDENT.