Akron Children's Hospital
SCHOOL HEALTH SERVICES

Non-Prescription Medication Administered at School

(Any medication that is purchased over the counter)

Attach Student Picture If available

School: _____

School Year: _____

Grade/Class: _____

Student Name:_____ Date of Birth:_____

Student Address: _____

Name of Medication: _____ Dose: _____

Time to be given (during school hours): _____

Reason for Medication to be administered:_____

Form of Medication: _____Tablet _____ Liquid _____ Other

Start date: _____ Stop date: _____

Special Instructions: _____

Potential adverse reactions to be reported to parent or doctor: _____

_____

Healthcare Provider Name: _____ Phone: _____

<u>Parent/Guardian:</u> I give permission for my child to receive this medication at school according to the school district policy.

I agree and am responsible to:

- **Deliver this medicine to school in its original container.**
- **Tell the school as soon as possible if there is a change in the use of this medicine**
- **Tell the school if my child gets a new healthcare provider**
- **Complete a new medicine form for this medicine if there are dose changes.**
- **If this medication is needed for greater than 5 consecutive days I understand that a healthcare provider order is required**
- **Dosage must be same or less than dose for age on bottle**

I agree for child's healthcare provider to talk with the school or any school staff person about this medication. No other part of my child's medical health will be discussed.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone: _____Emergency Alternate: _____

****THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR****