Assumption Catholic School

K-3rd Grades *N6217 Cty Rd V* *Durand WI 54736* *715-672-4276* *Fax 715-672-3485*

Pre School & 4-8 *901 W Prospect Street* *Durand WI 54736* *715-672-5617* *Fax 715-672-3931*

PARENT REQUEST FOR NON-PRESCRIPTION MEDICATION

Please administer the following medication to:

Name of Student _____Birth date _____

Address _____

Telephone Number _____Parent/Guardian Name _____

School _____Grade _____

Diagnosis or reason for medication: _____

Parent/Guardian Responsibilities:

1. **Notify the school of the child's needs.**
2. **Complete this non-prescription medication form permitting the school to give non-prescription medication in a dosage not to exceed the recommended dosage and frequency on the label.**
3. **Provide the non-prescription medication in its original container.**
4. **Notify the school in writing when the non-prescription medication should be discontinued.**

I/We further agree to hold the designated person(s) harmless in any and all claims arising from the administration of this non-prescription medication at school.

I/We further agree to notify the school in writing at the termination of this request or when any change in the above orders is necessary.

I request that the authorized school personnel administer the medication at the prescribed time to my child, and that school staff may be informed of the need for medication on a need to know basis.

Parent Signature _____Date _____

Medication Request:

DAILY MEDICATION					
Medicine	**Route**	**Dose**	**Frequency Time of Day**	**Duration**	**Possible Reaction**
				From: **To:**	
				From: **To:**	

PRN MEDICATION (As Needed)						
Medicine	**Route**	**Dose**	**Frequency Time of Day**	**Duration**	**Conditions under which medication should be given**	**Possible Reaction**
				From: **To:**		
				From: **To:**		