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 physician: ______________________________

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Physician/Healthcare Provider Name: ______________________________ Phone: ______________

Parent/Guardian: 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.**

Medication dosage outside of the dose indicated on bottle for the child's age requires a health care provider order. If this medication is needed for greater than 4 consecutive days, I understand that a healthcare provider order is required.

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

Parent/Guardian Signature: ______________________________ **Date:** ______________

Parent/Guardian Phone: ______________________ **Emergency Alternate Phone:** ______________________

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

Clinic Use Only: Date form received ____________ Date medication received: ____________ Form Complete (Y or N) _____

Notes: ______________________________________ Date Form complete: ____________