Haslett Public Schools
Authorization for Administration of
Non-Prescription Medication
Wilkshire - Murphy - Ralya - Elementary School (please circle school)

Date form was received at school _____

Name of Student:_____

Birth Date: _____ Grade:_____ Teacher: _____

To be completed by the parent/guardian:

Name of medication: _____

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

_____

Reason for medication: (Optional) _____

Form of medicine/treatment:

❍ Tablets/capsules ❍ Liquid ❍ Inhaler ❍ Other

❍ Additional dosage permitted in emergencies only by telephone call with parent.

Restrictions and/or pertinent effects: ❍ None anticipated.

❍ Yes, please describe: _____

Special storage requirements: ❍ None ❍ Refrigeration ❍ Other

Start Date if not the beginning of school: _____

Stop date if not end of the school year: _____

I request that _____receive the above medication at school according to standard school policy. (Name of student.)

_____ _____ _____
Parent/Guardian Signature Date Relationship

Physicians Name: _____ Phone #_____

Address: _____
