RMS PERMIT FOR DISPENSING NON-PRESCRIPTION MEDICATIONS

MEDICATION MUST BE IN ORIGINAL BOTTLE

In order to prevent the misuse of medication it is necessary to give permission for the use of non-prescription medications in the schools.

I am the parent of _____ _____
Child's Name Grade

The following non-prescriptive medication may be given to my child:

Medication Name _____

Time or Intervals _____ Dosage _____

Date of First Dose _____ Discontinue Date _____
(Two Week After First Dose)

Number of Days to be Given _____

Under What Condition _____

The medication will not be given unless this information is complete. Non-prescriptive medications are not to be kept by the student, they must be sent to the office immediately upon arriving at school.

My signature acknowledges that I am responsible for any adverse reactions to the non-prescriptive medication being given to my child while at school.

_____ _____
Parent/Guardian Signature Date

Date Given	Time Given	Staff Initial

Date Given	Time Given	Staff Initial