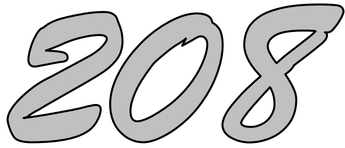
UNIFIED SCHOOL DISTRICT




# NON – PRESCRIPTION MEDICATION AUTHORIZATION

NAME OF STUDENT: _________________________________GRADE: ____________________________

MEDICATION, DOSE, AND ROUTE OF ADMINISTRATION: _______________________________________

_____________________________________________________________________________________

DATE MEDICATION STARTED: ___________ TIME TO BE GIVEN AT SCHOOL: _____________________

REASON FOR MEDICATION: ______________________________________________________________

N0. OF DAYS TO BE ADMINISTERED AT SCHOOL: ________ DURATION OF SCHOOL YEAR: YES NO

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I hereby give my permission for the above named student to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any drug or non-prescription medication pursuant to parental written request to my student in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse medication reaction suffered by the student because of administering such medication.

**NOTE: Medication is to be brought to school in the original container.**

DATE: _______________ ______________________________________________________________

**Signature of Parent or Guardian**

**Return completed form to:**
**Mandie Kinderknecht RN, School Nurse**
**612 Junction Ave.**
**WaKeeney, KS 67672**
**Fax # - 785-743-5244**