



**Exceptions to Medication Form
Mahomet-Seymour Schools**

Student _____ School _____

Medication _____ Dosage _____

I Parent/Guardian of _____ give permission for them to carry and use on School Grounds the above named Over the Counter Medication. My child has need for this medication as noted below, and I am aware that they have it in their possession. It will be contained in the original container and only small amounts will be kept at school. My child is instructed not to share this product with others and they know when and how to take it.

Parent/Guardian signature: _____

Date: _____ for the _____ school year.

Reason for Medication:

Medication exception approved:

School Nurse or Designee _____

Date _____