St. Croix Central School District
Non-Prescription Medication Administration Form

Medication and medication dose must be appropriate for the child's age/weight. If it exceeds recommended dose or is not recommend for the age of the child, a medical provider's signature is required. Please check expiration dates!

Student Name:_____ DOB:_____

Grade:_____ Teacher:_____

Allergies:_____

Medication Information

Drug Name:_____ Dose:_____

Time:_____ Reason for Medication:_____

I want this medication sent on field trips. □ **Yes** □ **No**

1. I understand I must provide this medication in the original container labeled clearly with the child's name.
2. I understand that written instructions must be provided when there is a change in medication, including but not limited to medication type, dosage or timing.
3. I will notify the school when the medication is discontinued and I will pick up the medication.
4. I will pick up the medication at the end of the school year. If my child is attending summer school, I will pick up the medication by the last day of summer school.
5. **I understand that medication orders must be renewed at the start of each school year.**

Parent/Guardian Signature:_____ Date:_____

Print Name:_____ Phone:_____

****Medical provider signature required if dose exceeds recommendation's on packaging or if not recommended for student's age.**

Medical Provider Signature:_____ Date:_____

Clinic Name:_____ Phone:_____