

**SCHOOL DISTRICT OF LADYSMITH
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION**

NON-PRESCRIPTION MEDICATION

Name of Student: _____ Birthdate: _____
Parent/Guardian: _____ Phone: _____
Address: _____
School: _____ Grade: _____ Teacher: _____

Part I - Parent's/Guardian's Statement

I hereby request the school to administer the following non-prescription medication. I further exonerate the School District of Ladysmith from any liability resulting there from.

1. Reason for medication _____
2. Name/type of medication _____
3. Dosage/amount to be given _____
4. Frequency/times to be administered _____
5. Duration (week, month, indefinite, etc.) _____

Parent's/Guardian's Signature Date Signed

Part II - Designated Person(s) Administering Drugs

I have agreed to administer the medication as requested by the parents/guardians and in accordance with directions listed above by the physician.

Signature of Person(s) Administering Medication Date Signed

IT IS THE POLICY OF THE SCHOOL DISTRICT OF LADYSMITH THAT MEDICATION BE BROUGHT TO THE SCHOOL IN THE ORIGINAL CONTAINER. ANY MEDICINE NOT IN THE ORIGINAL CONTAINER WILL NOT BE DISPENSED TO ANY STUDENT.