(Form 1)

SCHOOL CITY OF WHITING
AUTHORIZATION / REQUEST FORM
TO ADMINISTER NON-PRESCRIPTION MEDICATION

School Year: ______
Grade: ______

Student's Name ____________________ School NH WMS WHS Teacher ____________

Parent's Authorization and Request:

I authorize the designee of the above stated school to administer this non-prescription medication.

Date of this note: ____________________

Medication ____________________ Dosage ______________ Time __________

Reason student needs this medication: ________________________________

Parent / Guardian Signature ______________________________

Home Phone ____________________ Work Phone ____________________
Home Address ____________________

*I understand that the above medication must be picked up by me unless stated in writing is the person in which I give permission to pick up the medication on or before the last day of this school year.

ALL remaining medication will be discarded in accordance with the school's policy.

Signature ____________________ Date ____________________

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Printed Name