

NORTHEAST COMMUNITY SCHOOL DISTRICT

**PARENTAL AUTHORIZATION AND RELEASE FORM FOR THE
ADMINISTRATION OF PRESCRIPTION AND/OR NONPRESCRIPTION
MEDICATION TO STUDENTS**

Name of Student: _____

Parents' Phone Number: _____ Grade: _____

Medication: _____

Date to Begin: _____ Date to End: _____

Type: Prescription _____ Nonprescription _____

Dosage: _____

Time to Take: _____

SPECIAL INSTRUCTIONS FOR PRESCRIPTION/NONPRESCRIPTION MEDICATION:

I hereby request the Northeast Community School District school nurse, or his/her authorized representative, to administer the above-named medication to my child and agree to:

1. Submit this request to the principal or school nurse;
2. Personally ensure that the medication is received by the principal or school nurse administering it in the original, labeled container as dispensed by the prescribing physician or licensed pharmacist or is in the manufacturer's container;
3. Personally ensure that the container in which the medication is dispensed is marked with the medication name, dosage, interval dosage, and date after which no administration should be given.
4. Medication shall be delivered to school personnel by parent or delivered to the school in a **sealed envelope**.

Parent/Guardian's Signature

Date

Phone: (Home)

(Cell)

(Emergency)