# FRASER PUBLIC SCHOOLS

Request for Administration of Non-Prescription Medication to Student

Name of Student: _____ Date of Birth: _____ Grade:_____

School: _____ Date: _____

Under certain conditions, as a service to you and for the welfare of your child, school personnel may agree to honor parent and doctor requests for the administration of non-prescribed medication to students for limited periods of time. All medications must be in the original container, clearly labeled, and kept locked in the school office at all times.

## To be completed by Parent or Legal Guardian:

Name of Medication: _____ Dosage: _____

Frequency: _____

Restrictions and/or side effects: _____ None anticipated: _____

Date start medication: _____ Date stop medication: _____

____ Tablet/Capsule ____ Liquid ____ Other (specify) _____

I do hereby request and authorize administration of medication to be given to the above named student.

- I will assume responsibility for safe delivery of the medication to school.
- I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
- I release and agree to hold the Board of Education, its officials, and it employees harmless from any and all liability, foreseeable or unforeseeable, for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent or Legal Guardian | Printed name of Parent or Legal Guardian

Daytime phone number | Home phone number | Cell phone number