

BELGRADE DISTRICT SCHOOLS
PERMISSION FOR NON-PRESCRIPTION MEDICATION TO BE TAKEN AT SCHOOL

Name of student: _____ Grade: ____ Teacher: _____

Mother's daytime phone: _____ Father's daytime phone: _____

Name of medication: _____

Purpose of medication: _____

Time of day or how often medication may be taken: _____

Possible side effects: _____

Anticipated number of days medication needs to be taken at school: _____

Additional instructions: _____

I hereby give my permission for _____ to take the above
Student's name
medication at school as stated. I understand that it is my responsibility to furnish this medication.

Signature of Parent or Guardian

Date

Note: Medication is to be brought to/from school by parent or other responsible adult, in the ORIGINAL container (labeled with the student's name).