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 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).