

SOUTH KINGSTOWN SCHOOL DEPARTMENT
Authorization for Non-Prescription Medications to be Taken During School Hours
(MANUFACTURER-LABELED CONTAINERS ONLY)

School _____ Grade/Teacher _____

CHILD'S NAME _____ Sex _____ Date of Birth _____

Physician's Name/Address _____

Physician's Telephone _____

The following is to be completed by the PARENT:

I request that my child be assisted in taking the medicine(s) described below at school by the school nurse-teacher.

Additionally, in the event of an off site school-sponsored activity, my child may self administer this medication which shall be provided from home. Only one school day's supply should be provided and it will be transported in its original manufacturer-labeled container. This medication will be sent in on the day of the field trip. (If this procedure is not followed, the student will not be allowed to self-medicate on the off-site school sponsored activity.)

YES NO

I have read and understand the medication policy on the back of this page YES NO

Name of Medication _____

Dose/Time _____

Reason for medication _____

Length of time this treatment is recommended _____

Other Information:

Parent/Guardian Signature

Date

Home Phone

Emergency Phone