Anderson School District Two

Health Services

NON-PRESCRIPTION MEDICATION

My child, ____, needs to take the following non-prescription medication during the school day:

Medication:	**Dosage/time:**	**Why taken:**
________________________	_____________________	___________________
________________________	_____________________	___________________
________________________	_____________________	___________________

I understand that either the principal or his/her designee may assist this student with medication. I am aware that school employees are not licensed to administer medications and have had no special training in such procedures. Aspirin or medications containing aspirin will not be given without a physician's consent. All over the counter medications will be given according to weight/age as instructed on the label unless consent is obtained by a physician.

I hereby agree not to hold the school, school district or school personnel liable for any adverse reaction when the medication is taken as I have directed. I understand that the school district/principal may deny this request for legitimate reasons.

Parent Signature: ____ Date: ___________________

Phone number: _____________________________________

Teacher/grade: _____________________________________