PARENT REQUEST FOR ADMINISTRATION OF NON-PRESCRIPTION (OTC) MEDICATION

Dear Parents/Guardians:

In compliance with the Michigan School Laws, teachers and support staff of Allendale Public Schools may not administer any medication including non-prescription or over-the-counter (OTC) medication without a completed parent request form.

The Non-Prescription Medication must be provided in a marked container with your child’s name, name of medication, dosage and any specific directions for administration. Medication will be administered in the presence of another adult.

The parent request form is valid for the current school year only. Please complete, sign and return to your child’s school secretary.

___________________________________________________________

School Year _______________

Date_____________ Student Name _________________________________

Student Grade _______ School _______________ Teacher _______________

Medication ___________________________________________ Exp. Date _______________________

Dosage ___________________ Time/Days to be Administered ________________________

Condition for which medication is required ____________________________________________

_____________________________________________________________________________

Has your child taken this medication before? (Please circle) YES NO

Special Instructions/Precautions/Possible Side Effects __________________________________________

_____________________________________________________________________________

Physician’s Name ___________________________ Phone _______________________

My signature below indicates that I request that the APS staff administer the medication specified above to my child, and I am giving permission for APS staff to contact the physician for additional information, if needed.

Parent/Guardian Name (please print) ________________________________________________

Parent/Guardian Signature _____________________________ Date____________________

Daytime phone # (s)__________________________ / ________________________________