Martinsville City Public Schools **GRADES 9-12 ONLY**

Authorization for Nonprescription Medication to be Administered During School Hours Upon Request

(Original, sealed manufacturer containers only)

To be completed by the PARENT/GUARDIAN:

School _____ Grade/Teacher _____

Child's Name _____ Male/Female Date of Birth _____

Physician's Name _____

Address _____

_____

Condition(s) for which medication is to be given: _____

Name of Medicine _____ Dosage _____

NOTE: Nonprescription medication will not be administered beyond the maximum dosage listed in the manufacturer's directions unless an authorization form provided by the school division has been completed by the physician and the parent or legal guardian.

Method of administration _____

If medicine is to be given on a schedule, please list:_____

If there is any reason why the medication must be given at a specific time and not the present standard flexibility of ½ hour please specify. _____

If medicine is to be given "when needed" describe indications:

_____

How soon can it be repeated? _____

List any significant side effect: _____

Length of time medication is approved by parent/guardian: _____

Is child authorized to request medication for him/herself? _____

I hereby consent that authorized school personnel administer my child the medication listed above, in accordance with Martinsville City School Board policy.

Date _____ Parent/Guardian Signature _____

Home Phone _____ Emergency Phone(s) _____

Date _____ Received by School Nurse _____