



Permission Form for Non-Prescription Medication

HEALTH SERVICES DEPARTMENT
Waynesville R-VI School District

<http://waynesville.k12.mo.us/>

Date form received: _____

Student's Name _____

Grade _____ Date of Birth _____

Name of Medication _____

Dose and amount to be given _____

Time to be given _____

Route to be given mouth ear nose skin other _____

Will be given for what reason _____

Start date _____ Stop date _____

I hereby give permission for the above medication to be administered to my child at school according to school policy. I understand that all medications administered must be brought to school by the parent or their adult designee and can only be accepted if in the original labeled container. Students may not transport medications nor may the medications be given contrary to manufacturer's instructions.

Below signature also serves as authorization to discuss medication/health with prescribing physician.

If above said student withdraws from the district, medications will be destroyed after 10 days if not picked up by parent/guardian.

Signature _____

Date: _____