Spoon River Valley CUSD #4
32565 N IL 97, R.R. #1, London Mills, IL 61544 Phone: 309/778-2204

PERMISSION FORM FOR NON-PRESCRIPTION MEDICATION

Student: _____ Date of birth, or age: _____

Grade: _____ Teacher: _____

To be completed by the parent/guardian

Must this medication be given at school: ☐ No ☐ Yes

Reason for medication: _____

Name of medication: _____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Other _____

Instructions (Schedule and dose to be given at school): _____

_____

Start: ☐ date form received Other date: _____

Stop: ☐ end of school year Other date/duration: _____ (not longer than current school year)

☐ For episodic/emergency events only

Restrictions and/or important side effects: ☐ None anticipated ☐ Yes (Described below):

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other: _____

This student is both capable and responsible for self-administering this medication (medication must be stored in the office):

☐ No ☐ Yes-Supervised

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ As an attachment

I give permission for (student) _____ to receive the above medication at school according to standard school policy.

Date: _____ Signature: _____ Relationship: _____

Date form received by the school: _____

(06/03/02)