



# SIBLEY EAST PUBLIC SCHOOLS

## HEALTH SERVICES

202 3rd Ave. N.W.

PO Box 1000 | Arlington, MN 55307

(High School)P: 507.964.2292 | F: 507.964.8245

(Elem)P: 507.237.3317 | F: 507.237.3300

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### **ADMINISTRATION OF NON-PRESCRIPTION MEDICATION FOR STUDENTS**

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_ School Year \_\_\_\_\_

MEDICATION \_\_\_\_\_

PURPOSE OF MEDICATION \_\_\_\_\_

CHILD'S WEIGHT \_\_\_\_\_ DOSE (per bottle instructions) \_\_\_\_\_

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### **PARENT/GUARDIAN AUTHORIZATION**

1. The medication must be a non-prescription medication that does not contain aspirin, ephedrine/pseudoephedrine as the sole active ingredient or one of its active ingredients.
2. I will provide this medication in the original, properly labeled container.
3. If the administration of the medication is different from the manufacturer's label (i.e., exceeds dosage per age/weight), a licensed prescriber order will be required.
4. I release school personnel from any liability in the event that any reaction results from the administration of this medication.

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PARENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

HEALTH OFFICE STAFF RECEIVING MEDICATION \_\_\_\_\_ DATE \_\_\_\_\_

DISTRICT NURSE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_