

# SOUTH KINGSTOWN SCHOOL DEPARTMENT

Authorization for Non-Prescription Medications to be taken during school hours  
(MANUFACTURER-LABELED CONTAINERS ONLY)

School: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Physicians' Name/Address \_\_\_\_\_

Physician's Telephone \_\_\_\_\_

The following section is to be completed by the PARENT:

*I request that my child be assisted in taking the medicine(s) described below by the school nurse-teacher.*

*Additionally, in the event of an off-site school-sponsored activity, my child may self administer this medication which shall be provided from home. Only one school day's supply should be provided and it will be transported in its original pharmacy-labeled container. This medication will be sent in on the day of the field trip. (If this procedure is not followed, the student will not be allowed to self-medicate on the off-site school sponsored activity.)*

Yes  No

*I have read and understand the SOUTH KINGSTOWN SCHOOL DEPARTMENT MEDICATION POLICY.*

Yes  No

Name of Medication: \_\_\_\_\_

Dose/Time: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

List significant side effects: \_\_\_\_\_

Length of time this treatment is recommended: \_\_\_\_\_

Other Information: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_