GREATER JASPER CONSOLIDATED SCHOOLS
NON-PRESCRIPTION MEDICATION PERMISSION FORM

Student_____Grade_____Teacher_____

Reason for Medication_____
This student requires the administration of a non-prescription medication during school hours. The medication should be administered as follows:

Medication Exact Dosage Time to be given Stop Date

1._____

Parent Authorization for medication:

I hereby authorize school personnel to observe _____ taking the above medications during school hours as specified and in accordance with the medication's written instructions. I understand that any medication can only be administered as defined in the Student Medication Guideline and Procedures of the Greater Jasper Consolidated Schools.

_____ _____
Date Parent/Guardian Signature

***Note: Medication will not be given without all instructions fully completed*.**

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