Woodridge Local School District

NON-PRESCRIPTION MEDICATION ADMINISTERED AT SCHOOL

Attach Student Picture If available

School: _____

School Year: _____

Student Name: _____ Date of Birth: _____

Student Address: _____

Grade/Class: _____

Name of Medication: _____ Dose: _____

Time to be given (during school hours): _____

Reason for Medication to be administered: _____

Form of Medication: _____Tablet _____Liquid _____Inhaler _____Nebulizer _____Other

Start date:_____ Stop date: _____

Special Instructions: _____

Potential adverse reactions to be reported to parent or doctor: _____

_____

Doctor's Name: _____Phone: _____
Printed Name

To Be Completed by Parent/Guardian:
I give permission for my child to receive medication at school according to the school district policy and as instructed by the physician and agree to:

Assume responsibility for safe delivery of the medication in its original container to the school
Notify the school immediately if there is any change in the use of this medication
Have a new form completed by the doctor if medication or dosage is changed
Notify the school of changes in healthcare provider
Allow School Health Services staff to send and/or receive information related to my child's health, as they deem appropriate for the duration of this order as noted above

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Phone: _____

Alternate phone number in case of emergency: _____

****THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR****

9/1/01
8/02
4/13/10
12/14/11
2/20/13