Anderson School District One
School Health Services

NON-PRESCRIPTION MEDICATION

To Whom It May Concern:

My child, _____, needs to take the following non-prescription medication during school:

Medication	Dosage & Time	Why Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that either the principal or his designee may assist this student with medication. I am aware that school employees are not licensed to administer medications and have had no special training in such procedures. Aspirin or medications containing aspirin will not be given without a physician's consent. All over the counter medications will be given according to weight/age as instructed on the label unless consent is obtained by a physician.

I hereby agree not to hold the school, school district, or school personnel liable for any adverse reaction when the medication is taken as I have directed. I understand that the school district/principal may deny this request for legitimate reasons.

_____ _____
Parent's Signature *Date*

Home Phone: _____ Work Phone: _____

Cell Phone: _____

11/2014