LANCASTER SCHOOL DISTRICT

Laurie Walker, Lancaster School Nurse

861 West Maple Street

723-4066 Ext. 106

NON-PRESCRIPTION MEDICATION FORM

The following section is to be completed by the parent:

☐Winskill ☐Middle School ☐High School

Child's Name: _____

Last First Sex Birth date

_____

Physician's Name Address Telephone

Medication must be in the original container. Please try to supply the smallest container possible as locked storage space is limited.

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons.

**Dosages that are above the recommended dose on the bottle, must have a doctors signature included on this form.

_____

Date Parent/Guardian signature

The following section is to be completed by the PARENT:

Name of Medicine _____

Dose _____

Route _____

Time and Frequency _____

Other Information :

_____