Elementary fax 715-289-3017

Jr./Sr. High School fax 715-289-3085

School District of Cadott Community

Authorization for Administration of Medication: Non-Prescription Medication

Name of Student:_____ Date of Birth:_____

Parent/Guardian:_____ Phone:_____

Address:_____ Grade:_____

Part 1: Parent/Guardian's Statement:

I hereby give my permission for school personnel to administer medication to my child. I agree to hold the school district of Cadott community and its employees who may administer the medication harmless in any and all claims arising from the said administration of this medication at school. The school to administer the following non-prescription medication.

1. Name/type of medication:_____
2. Route:_____
3. Dosage/amount to be given:_____
4. Frequency/times to be administered:_____
5. Condition under which the medication should be given:_____

   _____
6. Duration (week, month, indefinite, etc.):_____
7. Known Allergies:_____

_____ _____

(Parent/Guardian's signature) (Date Signed)

It is required of the Cadott School District that medication be brought to the school in the **original** container, any medicine not in the **original** container **will not** be dispensed to any student.

Any medications that have an expired date will not be dispensed to the student. Any unused medications must be picked up by Parent/Guardian. Over-the-counter medications must be in containers of 50 or less pills. Nutritional supplements/dietary supplements or other substances not regulated by the F.D.A. shall not be administered by school personnel.