PHONE (All Offices) .... (406) 346-2796
Superintendent .... extension 5103
fax .... (406) 346-7455
Grades K-6 .... extension 5120
fax .... (406) 346-7797
Grades 7-12 .... extension 5140
fax .... (406) 346-9219
Business Office .... extension 5100
fax .... (406) 346-7455
Activities Director.............. extension 5321
fax .... (406) 346-7455

FORSYTH PUBLIC SCHOOL

"The Dogies"

SCHOOL DISTRICT NO. 4
AND
FORSYTH HIGH SCHOOL DISTRICT
P.O. BOX 319
FORSYTH, MONTANA 59327

Non-Prescription Medication Administered at School

(Any medication that is purchased over the counter)

Attach Student Picture If available

School: ______________________________

School Year: ____________________

Grade/Class: ____________________

Student Name: ____ Date of Birth: ____________________

Student Address: ____

Name of Medication: ____ Dose: __________________

Time to be given (during school hours): ____

Reason for Medication to be administered: ____

Form of Medication: _____Tablet _____ Liquid _____ Other

Start date: ________________ Stop date: ________________

Special Instructions: ____

Potential adverse reactions to be reported to parent or physician: _______________________________________

____

Physician/Healthcare Provider Name: ____________________________________ Phone: __________________

Parent/Guardian: I give permission for my child to receive this medication at school according to the school district policy. I agree and am responsible to:

- **Deliver this medicine to school in its original container.**
- **Tell the school as soon as possible if there is a change in the use of this medicine.**
- **Tell the school if my child gets a new healthcare provider.**
- **Complete a new medicine form for this medicine if there are dose changes.**

Medication dosage outside of the dose indicated on bottle for the child's age requires a health care provider order. If this medication is needed for greater than 4 consecutive days, I understand that a healthcare provider order is required. I agree for child's healthcare provider to talk with the school or any school staff person about this medication if needed. No other part of my child's medical health will be discussed. When my child receives this medication I will be notified.

Parent/Guardian Signature: ____ **Date:** __________________

Parent/Guardian Phone: ________________________ **Emergency Alternate Phone:** ________________________

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

Clinic Use Only: Date form received ______________ Date medication received: ____________ Form Complete (Y or N) ______

Notes: ____ Date Form complete: ____________

7/09, 4/10, 6/12, 5/13, 6/14, 6/15