FORSYTH PUBLIC SCHOOL
"The Dogies"
School District No. 4 and Forsyth High School District
PO Box 319
Forsyth, MT 59327
406-346-2796

Non-Prescription Medication Administered at School

(Any medication that is purchased over the counter)

Student Name:_____ Grade:_____ School Year:_____

Name of Medication:_____ Dose:_____ Time to be given:_____

Form of Medication:_____Tablet _____Liquid ____Other

Reason for medication to be administered:_____

Start Date:_____ End Date:_____

Special Instructions:_____

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.

Parent/Guardian Signature:_____ Date:_____

Parent/ Guardian Phone:_____

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