SCHOOL DISTRICT OF NEW RICHMOND

701 East Eleventh Street New Richmond, WI 54017, Telephone: (715) 243-7424 FAX: (715) 888-1551
Ryan Vang, R.N., District School Nurse, email: rvang@newrichmond.k12.wi.us

Parent(s)/Guardian Medication Request Form
Over-The-Counter Medication
Return this form to Health Office or Fax 715-888-1551

1. **Federal Drug Administration (FDA) approved over-the-counter medications will be administered with written parent permission.**
2. **The recommended dosage will be given following age/weight dosing on the package.**
3. **Dosages other than the recommended therapeutic dose on the packaging for age/weight require the written instructions of a medical provider.**
4. **The medication must be in the original manufacturer's container (no medication accepted in baggies).**
5. **All products not currently approved by the FDA will only be administered if ordered by a licensed medical provider. Such products include, but are not limited to, herbal, food supplements and home remedies.**

Student's Name: _____ Date of Birth: _____

School: _____Grade: _____Homeroom Teacher:_____

Over-the-counter Medication(s):

1. <u>Name of medication</u>: _____for the treatment of _____
Specific dose to be given at school:_____Time_____
Other specific directions: _____

2. <u>Name of medication:</u> _____ for the treatment of_____
Specific dose to be given at school: _____ Time:_____
Other specific directions: _____

I hereby request and give my permission for the school nurse, health assistant, or other designated school official to administer the following over-the-counter medication(s). I understand that the medication must be provided by me, in the manufacturer's prepared package with a non-expired date and that the dose will be administered for age/weight. Yearly written statements are required. The medication(s) must be picked up at the end of the school year.

Parent(s) Guardian Signature: _____ Date: _____

If any of the above medications are dosages other than the recommended therapeutic dose on the packaging for age/weight (#3 above) then physician permission below <u>MUST</u> be completed:

Physician's printed name_____Date: _____

Physician's signature _____Telephone number: _____

<u>This request/permission is valid for the current school year only.</u>

This medication request follows school board policy #5330 and is designed to protect students, parents and school personnel.

Revised February 7, 2023