Authorization to Administer <u>NON-PRESCRIPTION</u> Medication by School Personnel Stanley-Boyd Area Schools

Name of	Student	Date of Birth	Homeroom Teacher	Grade
Medication	on	Dosage	Time/Frequency	
Student's	physician			
Parent co	onsent nd the school will only admir	nister necessary medic	cations during the school	day.
	nd the school will not admini e recommended amount liste		s expired or at a dosage t	hat is
l will supp	ly the medication in its origin	al labeled container.		
I request t	hat this medication be admir	nistered at school by c	lesignated personnel.	
I authorize	school personnel to contact	my child's physician i	f needed.	
This conse	nt is in effect for the current	school year unless ot	herwise indicated.	
Date	Parent/Guardian Signatu	ire H	ome phone Worl	c phone

Note: It is the parent's responsibility to see that the school personnel receive this authorization. No medication will be given at school without signed consent of parent.