



---

## NON-PRESCRIPTIVE MEDICATION

---

### Request for Assistance with Medication

**Student Full Name:**

**Date of Birth:**

**School:**

**In my opinion, it is necessary that the following medication be administered to my child when necessary.**

Oral Medication      Other (please specify)

Name of Medication:

Purpose of Medication:

Dosage:

Expiry Date:

Frequency During School Hours:

Duration of Medication:

Anticipated Reaction to Medication:

Is Medic Alert Bracelet or Necklace Worn:      Yes      No

Allergy Identification:

Is Allergy Life Threatening:      Yes      No

I request and hereby give permission that my child, be assisted in taking the medication specified above. I agree that it is my responsibility to furnish and deliver the medication, which shall be labeled with the names of my child, the name, dosage and frequency of the medication. This request will expire on the last school day of June each year, or upon written request. I understand that any staff person involved in these procedures is acting "in loco parentis" and not as a health professional.

I prefer to provide the assistance in medication personally.

Date:

---

Signature of Parent Assisting in Medication

\_\_\_\_\_  
*Person Assisting in the Administration of Medication*

I have agreed to assist in the administration of the Non-Prescriptive Medication as herein requested by the parent and to maintain a log of such assistances. I also understand that I am assisting in administering this medication under the principle of "in loco parentis", and not as a health professional. I am aware of the potentially severe nature and proper treatment of the medical condition.

Date:

---

*Alternate*

Approval Section (valid until end of current school year)

Approved

Effective:

Not Approved

Reason for Non-Approval:

---

Date:

---

*Principal's Signature*