

**Anderson School District One  
School Health Services**



**NON-PRESCRIPTION MEDICATION**

To Whom It May Concern:

My child, \_\_\_\_\_, needs to take the following non-prescription medication during school:

Medication	Dosage & Time	Why Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that either the principal or his designee may assist this student with medication. I am aware that school employees are not licensed to administer medications and have had no special training in such procedures. Aspirin or medications containing aspirin will not be given without a physician's consent. All over the counter medications will be given according to weight/age as instructed on the label unless consent is obtained by a physician.

I hereby agree not to hold the school, school district, or school personnel liable for any adverse reaction when the medication is taken as I have directed. I understand that the school district/principal may deny this request for legitimate reasons.

\_\_\_\_\_  
*Parent's Signature* \_\_\_\_\_  
*Date*

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_