



School District of Somerset
Non-Prescription Medication Request Form

Name of Student: _____ Grade: _____

Date of Birth: _____ Allergies: _____

To Be Completed by a Parent/Guardian

Name of Medication: _____ Dose: _____

Form of Medication:

Tablet/capsule Liquid Injection Topical Inhaler Nebulizer Drops

Time to be given: _____

Illness/Condition requiring medication: _____

Length of time to be administered: _____

I want this medication sent on field trips: Yes No

I give the above student permission to self-carry and administer medication Yes No

*****Medication and medication dose must be appropriate for the child's age/weight. If it exceeds the recommended dose or is not recommended for the age of the child, a medical provider's signature is required.**

1. I request the above medication be given as prescribed by the manufacturer's instructions
2. I understand I must provide the medication in the original container and labeled with the student's name. I understand that medication will not be accepted in a baggie or other non-manufacturer container
3. I will notify the school when the medication is discontinued
4. I will pick up the medication at the end of the school year, or request it be sent home with my student. If my child is attending summer school, I will pick up the medication by the last day of summer school
5. All products not currently approved by the FDA will only be administered if ordered by a licensed medical provider
6. I understand that medication orders must be renewed each school year

7. I understand that when my child is on a field trip, the above medication will be given to the appropriate teacher to supervise and administer

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Phone: _____

How would you like to be contacted if/when refills are needed: Phone Email
 Other: _____