



**NON – PRESCRIPTION  
MEDICATION AUTHORIZATION**

NAME OF STUDENT: \_\_\_\_\_ GRADE: \_\_\_\_\_

MEDICATION, DOSE, AND ROUTE OF ADMINISTRATION: \_\_\_\_\_

\_\_\_\_\_

DATE MEDICATION STARTED: \_\_\_\_\_ TIME TO BE GIVEN AT SCHOOL: \_\_\_\_\_

REASON FOR MEDICATION: \_\_\_\_\_

NO. OF DAYS TO BE ADMINISTERED AT SCHOOL: \_\_\_\_\_ DURATION OF SCHOOL YEAR: YES NO

I hereby give my permission for the above named student to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any drug or non-prescription medication pursuant to parental written request to my student in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse medication reaction suffered by the student because of administering such medication.

**NOTE: Medication is to be brought to school in the original container.**

DATE: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Parent or Guardian**

**Return completed form to:  
Mandie Kinderknecht RN, School Nurse  
612 Junction Ave.  
WaKeeney, KS 67672  
Fax # - 785-743-5244**