Graham Local School District

<u>Non-Prescription Medication Authorization Form</u>

All blanks must be completed

1. ____
   Pupil's name, complete address, and phone number

2. ____
   Building and grade level of pupil

3. ____
   Name of non-prescription medication and dosage to be administered

4. ____
   List the time of day non-prescription medication is to be administered

5. ____
   List the date the administration of the non-prescription medication is to begin

6. ____
   List the date the administration of the medication is to cease

7. ____

   ____
   List all special instructions for the administration of the non-prescription medication including sterile conditions and storage

* *

I, ___________________________________, request that authorized personnel of Graham ____________________
Name of Parent/Guardian Building

administer the above medication to my son/daughter, ______________________________________, according
Name of Pupil

to the written instructions. I further agree to relieve the Graham Local Board of Education and its employees of

liability for administration of the non-prescription listed on this form.

______________________________ ____________________________________
Date Signature of Parent/Guardian