**Request for Supervision of Self-Administration of**

**Over-the-Counter (OTC)/Non-Prescription Medication at School**

Albany County School District One

Laramie, Wyoming

 School:       Grade/Teacher:

**STUDENT INFORMATION**

**Name: *last name***       ***first name***

**Birthdate:**   **/**  **/**     **Age:**    **years Weight*:***       **pounds**

**Allergies: (*Please circle if applicable)* NKDA (no known drug allergies) (*OR list any drug allergies below):***

**MEDICATION INFORMATION**

***(NOTE: EVERY MEDICATION MUST BE IN ITS ORIGINAL CONTAINER.)***

**Name of Medication:**

**Expiration date:**   **/**  **/**     **Start date:**   **/**  **/**     **End date:**   **/**  **/**

**Dosage:**

**Time(s) to be taken at school:**

**Route (how medication is to be taken):*(Please check)*** **[ ] oral** **[ ] inhaled** **[ ] to skin** **[ ] to eyes** **[ ] to ears**

**[ ]  other (*Please explain)*:**

**Health Concern (reason for taking medication):**

**Side Effects:**

**Other Medications Currently Taken by Student:**

**Comments/Additional Information:**

**By signing below,**

1. **I am requesting that the medication listed above be taken by my child as directed above, only under the supervision of designated school personnel. I understand that it is my child’s responsibility to report to the nurse’s office for this purpose.**
2. **I acknowledge having read and understood Albany County School District One’s Policy on Medication Self-Administration at School, which is printed on the back of this form.**

***parent/guardian signature***  ***date signed***  ***/***  ***/***

***emergency contact phone number***    ***-***   ***-***

APPROVED BY:

School Nurse:       date:   /  /

School Principal:       date:   /  /