Hurley School District
NON-PRESCRIPTION
MEDICATION AUTHORIZATION FORM

Student Name: ____ **DOB:** ____________

Parent/Guardian: ____

Home Phone: __________________ **Work:** ________________ **Cell:**_______________

Health Care Provider: __________________________ **Phone:** ___________________

Medication Name: ____
Dosage: ____________________________ **Time Given:** _________________________
Condition/Illness/Injury being treated with medication: ______________________
Effective Date: _____________ **To:** ________________ **Exp. Date:** ________________

Medication Name: ____
Dosage: ____________________________ **Time Given:** _________________________
Condition/Illness/Injury being treated with medication: ______________________
Effective Date: _____________ **To:** ________________ **Exp. Date:** ________________

Additional Comments:
____
____
____

Reminder: All medication brought to school must be in the original sealed container.

I hereby give permission to school employees designated by school officials to give medication to my child according to the direction stated above.

I further agree to notify the school in writing at the termination of this request or when any mediation changes occur.

Parent Signature: _____________________________________ **Date:** ______________

***Any dose other than the recommended dose on the container will require a Physician's written order and signature below.**

Physician's Signature: _________________________________ **Date:** ____________

Clinic: ____ **Phone:** _____________