Iron Mountain Public Schools

Non-prescription Medication Permission

Name of Student:_____ **Grade:**_____

Age:_____ **Homeroom Teacher:**_____

Parent/Guardian:_____ **Phone:**_____ **Work:**_____

Medication(s):	1._____	2._____	3._____
Dose:	1._____	2._____	3._____
Time to Admin:	1._____	2._____	3._____
Route:	1._____	2._____	3._____
Duration of Effect:	1._____	2._____	3._____

I hereby request that my child be administered the above medication. All medication MUST be in the : ORIGINAL container, and properly labeled with the student's name. The school nurse reserves the right to refuse medication administration if evaluated as inappropriate.

Your signature will be valid for this school year only.

Parent/Guardian Signature_____ **Date:**_____

Medication Given	Dose	Date	Time	Initials