

MONTOURSVILLE AREA SCHOOL DISTRICT

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NON-PRESCRIPTION MEDICATION FORM

Date: \_\_\_\_\_

School Year \_\_\_\_\_ - \_\_\_\_\_

Student: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

MEDICATION	STRENGTH	DOSAGE	TIME TO BE GIVEN	ROUTE	DURATION OF ORDER

Purpose of Medication:

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Side Effects:

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Comments; \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature and date

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PARENTAL PERMISSION FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_  
(Name of parent/guardian) (Name of student)

Hereby authorize the **MONTOURSVILLE AREA SCHOOL DISTRICT's** school nurses to administer the above non-prescription medication to the above named student. The Non-Prescription medication will be accompanied by the prescribing physician's instructions and in the **original** and properly labeled container.

\_\_\_\_\_  
Parent/Guardian Signature