

School District of Spring Valley
S1450 County Road CC
Spring Valley, WI 54767
Elementary – 715-778-5602 Fax – 715-778-5615
Middle-High School – 715-778-5554 Fax – 715-778-5556

Administration of Non-Prescription Medication

Name of Child: _____	DOB: _____	Grade: _____
Address: _____	Phone: _____	

Medication Information

Drug Name _____	Dosage _____
Frequency _____	
Time _____	Route _____
Start Date _____	Stop Date _____
Reason for medication _____	
My child has allergies to _____	

Parent Signature and Information

1. I request this medication be given as directed. I understand I must provide this medication in the original sealed container, labeled clearly with the child's name.
2. I understand that written instructions must provide when there is a change in medication, including but not limited to medication type, dosage or timing.
3. I will notify the school in writing when the medication is discontinued and I will pick up the medication.
4. I will pick up the medication at the end of the school year. If my child is attending summer school, I will pick up the medication by the last day of summer school.
5. I understand that medication orders must be renewed when specified.

Parent/Guardian Signature: _____	Date: _____
Print Name: _____	Phone: _____ Work/Cell: _____