METROPOLITAN SCHOOL DISTRICT OF WASHINGTON TOWNSHIP

8550 Woodfield Crossing Boulevard, Indianapolis, IN 46240 (317) 845-9400

5330 F/Y
Yellow

AUTHORIZATION FOR NON-PRESCRIBED MEDICATION OR TREATMENT

Parent/Guardian: THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO RECEIVE NON-PRESCRIBED MEDICATIONS/ TREATMENT IN SCHOOL. **ALL SPACES MUST BE COMPLETED.**

Name of Student _____ Address _____

School _____ Grade _____ Date of Birth _____ Child's Current Weight _____

A. I am requesting that an authorized representative of the MSD Washington Township administer the following over-the-counter medication(s). All nonprescription medication must be approved by FDA or under the advice of a physician/practitioner with signed orders.

1. Non-Prescription Medication/Treatment: _____

   Dose/Frequency: _____

   Directions for Administration/Side Effects _____

   _____

   Medication Administration Beginning Date: _____ End Date: _____

2. Non Prescription Medication/Treatment: _____

   Dose/Frequency: _____

   Directions for Administration/Side Effects _____

   _____

   Medication Administration Beginning Date: _____ End Date: _____

****NOTE: If the requested dose or frequency does not match the weight based dose, a physician's signature is also required.**

X_____

(Signature of Physician/Practitioner only required for non FDA approved medication and change in normal dosing.)

B. For all students grades K-8 and preschool, I will assume responsibility for safe deliver to the school health clinic at the beginning of the school year and *retrieval from school at the end of the school year.* **Preschool and students grades K-8 MAY NOT transport medication(s) to and from school.** *Medications left at school following the close of the school year will be destroyed.*

C. **North Central students may transport medication(s) to and from school if this form (5330 F/Y) is on file and signed by the parent/guardian.** *Medications left at school following the close of the school year will be destroyed.*

D. I will notify the school in writing if there is any change in the use of the medication(s)/treatment:

X_____ _____

Signature of Parent/Guardian Date

_____ (H)_____(W)_____

Printed Name of Parent/Guardian Telephone Numbers

PERMISSION IS VALID ONLY FOR THE CURRENT SCHOOL YEAR AND ONLY FOR THE STUDENT LISTED ON THE FORM. STUDENTS ARE NOT PERMITTED TO SHARE THEIR MEDICATION WITH OTHER STUDENTS. VIOLATIONS WILL RESULT IN DISCIPLINARY ACTION.