The International School of Minnesota

School Year 2017-2018

Parental Request for Administration of Non-Prescription Medication

Student Name _____Teacher _____ Grade _____

Medication (circle one): Tylenol / Ibuprofen / Other (specify)_____

Time of Administration _____

Dosage_____

Date Medication is to: Begin _____ End _____

Possible Side Effects _____

Special Instructions _____

Physician's Name_____ Phone Number _____

I, the undersigned, give permission to The International School of Minnesota personnel to administer or supervise my student taking the above medication. I further agree to indemnify and hold harmless The International School of Minnesota and its agents, all claims as a result of any and all acts performed under this authority.

_____ _____

(Signature of Parent/Guardian) (Date)

Date	Time	Amt	By	Date	Time	Amt	By