



NON-PRESCRIPTION MEDICATION

PARENT REQUEST TO ADMINISTER (2018-2019)

Student Name _____ Grade _____

- I request The International School of Minnesota Health Office staff to administer the following medication as needed for pain for the entire 2018-2019 school year (check all that apply):

_____ Tylenol _____ Ibuprofen _____ I do not request either of these medications

Dosage _____ Possible Side Effects _____

- Please specify if you would like request any other non-prescription medicines to be administer:

Medication _____

Beginning Date/End Date _____ Dosage _____ Time _____

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.

Parent/Guardian Signature _____ Date _____

- I would like to be contacted prior to my child receiving any medication: _____ Yes _____ No

If yes, please provide phone number or email: _____

Date	Time	Amt	By	Date	Time	Amt	By
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____