Willowwind School Request to Administer
NON-PRESCRIPTION Medication in Preschool or School, B/ASP

Expiration Date______________________________________________

Non-Prescription medications can/may be administered at school only with written authorization from the parent or guardian as follows:

Date: ____________
Child’s Name: ______________________________________________
Medication: ____________________________________________________

Needed during school day? _____ Yes _____ No
Number of days to be given: _____________________ or as needed _________
Dosage: ____________________ Give at: ____________________
                        AM                      PM
Side effects: _________________________________________________
Special instructions: ____________________________________________

Physician’s Name: ______________________________________________
Physician’s Office & Phone Number ________________________________

☐ I have provided Willowwind School, Preschool and B/ASP with my child’s non-prescription medication. It is in the original container with his/her name attached. I request that authorized staff make provisions for my child to receive the medication as advised above.

Signed: _______________________________________ Date: ____________________
     Parent/Guardian Signature