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# LONG TERM NON-PRESCRIPTION MEDICATION REQUEST

**STUDENT NAME (PRINTED):** _____ **AGE:**_____ **GRADE:** _____ **SCHOOL I.D. #** _____

**Allergies (Medication):** _____

As parent/guardian of the above named student, I request the School District to give medicine for the following condition(s) ***(Check all that apply***)

**CONDITION:** ☐ **Headache** ☐ **Cramps** ☐ **Dental** ☐ **Other:** _____

**MEDICINE:** ☐ **Acetaminophen** ☐ **Ibuprofen** ☐ **Naproxen** ☐ **Midol/Premsyn/Pamprin** ☐ **Other** _____

**Dose:** _____ **Frequency:** _____ **Specify Time:** _____ **or As Needed:** _____

I understand that the school is not legally obligated to administer medication to my child. Therefore, I agree to defend and hold harmless, the school district and its employees from any liability for the results of the medication or the manner in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements. Medication request must be deemed necessary to maintain or improve health and participation in the school program. Each request will be assessed for the most appropriate intervention and will be given at the standard dosage recommended by