



School Year _____

Grade _____

MADISON COUNTRY DAY SCHOOL
Phone: 608-850-6000 Fax: 608-850-6006

REQUEST FOR ADMINISTERING **NON-PRESCRIPTION MEDICINE**

Parent or Guardian Statement:

I request that _____ receive the medication listed
Child's Name

below for the period from _____ to _____ .
Date Date

The medicine is to be furnished by the parent in the original container. Please write the child's name on the container.

Name of Drug: _____

Dosage: _____

Time of Day to be Given: _____
(If noon, please indicate if it should be given before or after the child eats lunch.)

Illness or Reason for Medication: _____

I agree to hold both Madison Country Day School and their authorized personnel harmless in any and all claims arising from the administration of this medicine.

Parent/Guardian Signature: _____

Date: _____ Daytime Telephone: _____