



PARENT/GUARDIAN, please complete the following:

\_\_\_\_\_  
(Name of Student-Please print)

\_\_\_\_\_  
(Program)

I hereby request that an authorized representative of AYS administer the **non-prescription** medication listed below to my son/daughter. I understand that I may withdraw this consent at any time by submitting a written request to AYS personnel. Furthermore, I understand this consent is valid for only one school year.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

Name of **non-prescription** medicine: \_\_\_\_\_

Dosage & directions for administration: \_\_\_\_\_

Purpose: \_\_\_\_\_

**\*\*If your child attends a licensed AYS program, your child's physician is also required to complete the following:**

\_\_\_\_\_ is a patient under my care. The following **non-prescription** medication would need to be administered during the AYS program. The following is a description of the medical order:

Name of the **non-prescription** medication: \_\_\_\_\_

Dosage & directions for administration: \_\_\_\_\_

Purpose: \_\_\_\_\_

Possible side effects to be reported: \_\_\_\_\_

\_\_\_\_\_  
(Physician Signature)

\_\_\_\_\_  
(Physician Printed Name)

\_\_\_\_\_  
(Date)

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