AUTHORIZATION FOR NON-PRESCRIBED MEDICATION OR TREATMENT

To The Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NON-PRESCRIBED MEDICATIONS IN SCHOOL. ALL AREAS MUST BE COMPLETED.

_____ _____

Name of Student Address

_____ _____

School Grade

A. I am requesting permission for my child named above to: (Check one or both)

_____ Use or receive the following over-the-counter medication(s)

Medication: _____

Dosage: _____

Medication: _____

Dosage:_____

_____ Self-administer such medication(s) in the presence of an authorized staff member

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication on the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____

Signature of Parent Date

_____ _____

Home Telephone Work Telephone