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 spaces must be completed.

Student name:_____

Address:_____

School:_____ Class/grade:_____

A. I am requesting permission for my child named to: (check one or both)
   - ☐ Use or receive the following over-the-counter medication(s):

     Medication(s):_____

     Dosage(s):_____

     Check option 1 or 2 below:
     - ☐ Self-administer such medication(s) in the presence of an authorized staff member
     - ☐ Keep the medication(s) in his/her possession and self-administer the medication(s) as needed
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 or the prescribed treatment
D. Our physician has instructed that this medication should be administered in the above designated dosage
E. Prescribed medication should be provided in the original container with specific items listed
F. 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 any damages or injury resulting directly or indirectly from this authorization

Parent signature:_____ Date:_____

Home phone:_____ Work phone:_____

Authorization for Staff

The following staff members are authorized to administer the above prescribed medication(s)/treatment(s):_____

_____

Principal:_____