Authorization for Non-Prescribed Medication or Treatment (Elementary Version)

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) or FDA-approved topical substances:

     Medication(s):______________________________

     Dosage(s):______________________________
   - ☐ 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 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:____________________