

**ALMONT COMMUNITY SCHOOLS****AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT**  
**(ELEMENTARY VERSION)**

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE  
NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES 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) or FDA-approved topical substance(s).

Medication/topical substance: \_\_\_\_\_

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 or the prescribed treatment.

D. Our physician has instructed that this medication should be administered in the above designated dosage.

E. 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.

F. Any medication should be provided in the original container with specific items listed.

\_\_\_\_\_  
Signature of Parent\_\_\_\_\_  
Date\_\_\_\_\_  
Home Telephone\_\_\_\_\_  
Work Telephone**AUTHORIZATION FOR STAFF**

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

\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_  
Principal

12/17/18