Van Buren Elementary School

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AUTHORIZATION FOR NON-PRESCRIBED MEDICATION OR TREATMENT

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

_____ _____
Name of Student Address

_____ _____
School Class/Grade

A. I am requesting permission for my child named above to receive the following over-the-counter medication:

Medication:_____

Dosage:_____

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 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 Phone Cell Phone Work Phone