SPRINGPORT PUBLIC SCHOOL
MEDICATION AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT

PARENT PERMISSION

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Student(s) Name _____ DOB _____ Gender (M) (F)

Address _____

School: (ES) (MS) (HS) Teacher/Grade _____

I am requesting permission for my child named above to use or receive the following over-the-counter medication(s)

Medication: _____ Dosage: _____ When to be given _____

Medication: _____ Dosage: _____ When to be given _____

Medication: _____ Dosage: _____ When to be given _____

Medication: _____ Dosage: _____ When to be given _____

Medication: _____ Dosage: _____ When to be given _____

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

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

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

_____ _____ _____
(Parent/Guardian Signature) **(Contact #)** **(Date)**

Physician Information for office use only

Physician Name: _____ Phone: _____

Telephone: (517) 857-3475 / Fax: (517) 857-3251 / Web Page: springportschools.net