Over-The-Counter-Medication

Name:_____ The School District requires all of the following information before it will administer medication to this student.

School:_____

Grade:_____

Authorization for Administration of Over -The-Counter Medication or Non-Prescribed

Parent Authorization for Over-The-Counter Medication

A. I am requesting permission for my child named above toL
(Check one or both)

_____use or receive the following over-the counter medications(s)

Medication:_____

Dosage:_____ at the following time_____.

_____self-administer such medication(s) in my presence or that 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.

D. 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.

_____ _____
Signature of Parent Date

_____ _____
Home Telephone Work Telephone

Authorization for Staff

The following staff members are authorized to administer the above prescribed or over-the-counter medication(s) to the student:_____

_____

_____Principal

Name:_____

School:_____

Grade:_____

The School District requires all of the following information before it will administer medication to this student.

Authorization For Administration of Prescribed Medication

Physician Statement

_____, is under my care & I have prescribed the following
(Name of student)
medication _____ to be given at the following time_____.
(Name of drug,dosage & route)
Medication is to begin _____ and end on_____.
(Date) (Date)
Instructions or precautions (including possible side effects) :_____

_____

_____

If applicable, please check: _____This student is capable and responsible to self-administer this medication _____ with or _____ without supervision.

Date_____ Physician Signature _____

Telephone_____ Printed/Typed Name_____

_____

** Parent Authorization for Prescribed Medication**

A. I am requesting for my child named above to: (Check one)
_____ use or receive the above prescribed medication
_____ self-administer medication

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,

D. 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 all authorization.

_____ _____
Signature of Parent Date

_____ _____
Home Telephone Work Telephone