USD #415

STAFF ADMINISTRATION OF *OVER-THE-COUNTER* MEDICATION

Name of Student _____ DOB _____

School _____ Grade _____

Teacher(s) _____

Medication _____ Dosage _____

Date Medication to start at school _____ Reason for Med _____

Time of day medication is to be given at school _____

Expected duration _____

I hereby give my permission for _____ to take the above over-the-counter medication. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any drug to my student in accordance with written instructions from the legal guardian shall not be liable for damages from an adverse drug reaction suffered by the student as a result of administering such drug or because of mislabeled or altered products.

_____ _____

DATE PARENT/GUARDIAN SIGNATURE

NOTE: The medication is to be brought to school in the original container, appropriately labeled, stating the name of the medication, the dosage, and frequency to be administered.

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