AUTHORIZATION FOR NONPRESCRIPTION DRUG PRODUCTS OR TREATMENT

TO THE PARENT/GUARDIAN:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIPTION DRUG PRODUCTS IN SCHOOL.

ALL SPACES MUST BE COMPLETED.

Name of Student	Date of Birth	Grade	School
Address	City, State, Zip		

A. I am requesting permission for my child named above to receive:

Medication: _____

The medication container must be the original manufacturer's package and the package must list in a legible format the ingredients, recommended dose, special handling and storage directions. (Nonprescription drug products include cough drops that contain active ingredients.)

Dosage and Frequency: _____

School personnel may administer a nonprescription drug product to a student in a dosage other than the recommended therapeutic dose only if the request to do so is accompanied by the written approval of the pupil's doctor.

Reason for Giving Medication: _____

Beginning Date: _____ **Ending Date:** _____

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

_____ _____
Signature of Parent Date

_____ _____
Home Phone Work Phone

AUTHORIZATION FOR STAFF

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

_____

_____

_____
School Nurse Signature