

USD 378

PERMISSION FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATION AT SCHOOL

Please fill out all information below

Name of Student: _____

School: _____ Grade: _____ Teacher: _____

Medication: _____

Dosage: _____

Date started: _____ Date stopped: _____

Time of day medication is to be given: _____

I hereby give my permission for _____ to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I also understand that this medication will only be given on the days specified above and the medication will be sent home. I further understand that any school employee who administers any drug or nonprescription medication pursuant to parental written request to my student to accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse medication reaction suffered by the student because of administering such medication.

Signature of Parent/Guardian: _____ Date _____

Note: If a "stop date" is not indicated, the medication will be sent home at the end of the day of the "start day".

The medication is to be brought to school in the original container.

If the over the counter medication is a medication that is prescribed by a physician, the medication must be appropriately label by the pharmacy or physician stating the name of the medication, the dosage and time to be given.