AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT
(SECONDARY VERSION)

To the Parent:

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

Name of Student _____ Address _____

School _____ Grade _____

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

[ ] use or receive the following over-the-counter medication(s).

Medication: _____
Dosage: _____

Check Option 1 or 2 below.

[ ] self-administer such medication(s) in the presence of an authorized staff member.

[ ] keep the medication(s) in his/her possession and self-administer the medication(s) as needed.

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.

E. 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 medication(s)/treatment(s): _____

_____

Principal _____