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 Class/Grade

_____
Health Concern: (e.g. headache, cramps)

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

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

Medication: _____

Dosage: _____

Frequency: _____

☐ self-administer such medication(s) in the presence 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 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 foreseeable or unforeseeable 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-nonprescribed medication(s)/treatment(s):

_____
_____

_____
Principal

10/2015