

AUTHORIZATION FOR NON-PRESCRIBED MEDICATION OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NON-PRESCRIBED MEDICATION IN SCHOOL. PLEASE COMPLETE ALL AREAS.

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Address

\_\_\_\_\_  
School

\_\_\_\_\_  
Grade

1. I am requesting permission for my child named above to:  
\_\_\_\_\_ use or receive the following over-the-counter medication(s)

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

- A. Self-administer such medication(s) in my presence or that 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. 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 or injury resulting directly or indirectly from this authorization.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home Telephone

\_\_\_\_\_  
Work Telephone