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