

<u>AUTHORIZATION FOR NONPRESCRIBED MEDICATION</u> (Secondary Version)

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED. Please use a separate form for each medication.

Name of Student So			ol .	Class/Grade
Address			Birthdate	
A.	I am requesting permission for my child (name above) to: (Check all that apply)			oly)
		Use or receive the following over-the-counter medication:		
		Medication Name:		
		Dosage:		
		Reason for medication:		
		Be administered such medication by an au	thorized staff member.	
		Self-administer such medication in the pres	sence of an authorized staff i	member.
		I give permission for my student to carry school or home.	and self-administer cough	drops provided from
B.	I will	I will assume responsibility for safe delivery of the medication to school.		
C.	I will	I will notify the school immediately if there is any change in the use of the medication.		
D.	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	
Primary Telephone Number			Additional Telephone Numl	ber

AUTHORIZATION

Only employees or contractors of the Board who are licensed health professionals or who have completed a drug administration training program conducted by a licensed health professional and are designated by the Board may administer prescription and nonprescription drugs to students in school.