

<u>AUTHORIZATION FOR NONPRESCRIBED MEDICATION</u> (Elementary 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			School	Class/Grade	
	000			Birthdate	
Address				Dirindate	
A.	I am requesting permission for my child name above to: (Check all that apply)				
		☐ Be administered the following over-the-counter medication by an authorized staff member.			
		Medication Name:			
		Dosage:		_	
		Reason for medication:			
B.	l wi	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.				
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 Number		

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.

1/14/13 3/18/13