AUTHORIZATION FOR NON-PRESCRIBED MEDICATION OR TREATMENT

To the Parent:

The following information is necessary for any student to receive non-prescribed medications in school. These medications will be available and administered in the office/ Health Clinic. All spaces must be completed.

_____ _____
Name of Student Address

_____ _____
School Class/ Grade

A. I am requesting permission for my child named above to receive the following over-the-counter medication(s) supplied by the school. Check the medications that apply:

Acetaminophen/ Tylenol _____ (dose recommended per age on bottle)
Ibuprofen/ Motrin _____ (dose recommended per age on bottle)
Neosporin Ointment _____
Benadryl anti-itch Cream/ Spray _____
Aloe Vera Lotion _____
Cough Drops _____

B. I will notify the school immediately if there is any change in the use of the medication.

C. 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

Medications can only be administered by a licensed healthcare professional or by a staff member who has been trained in medication administration by a licensed healthcare professional.

5/17/16