ADMINISTRATION OF OVER-THE-COUNTER or NON-PRESCRIBED MEDICATIONS

Great Oaks Policy 5330 requires consent of the parent/legal guardian before school personnel can give any **over the counter/non-prescription medication** to a student. Please complete this form and return to the school office.

Name of Student _____DOB _____ Grade _____ Campus _____

Address _____ Telephone _____

Allergies _____

To be completed by PARENT/GUARDIAN

PLEASE CHOOSE ONE OF THE TWO OPTIONS BELOW

☐ I am requesting permission for my student named above to KEEP THE ALL OVER-THE-COUNTER MEDICATIONS LISTED BELOW IN THE SCHOOL NURSE'S OFFICE. When needed, the medication is to be administered in the presence of an authorized staff member at the dosage indicated below:

Medication:_____

Dosage:_____

Medication:_____

Dosage:_____

Medication:_____

Dosage:_____

☐ I am requesting permission for my student named above to SELF-CARRY and SELF-ADMINISTER all over-the-counter medications listed below, at the dosage indicated below:

Medication:_____

Dosage:_____

Medication:_____

Dosage:_____

Medication:_____

Dosage:_____

- I understand Great Oaks does not provide any medications. I will assume responsibility for safe delivery of the medication to school. All medication must be in the original container.

- I will notify the school immediately if there is any change in the use of the medication or prescribed treatment.

- I release and agree to hold the Great Oaks Board of Directors, 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.

_____ ____/____/____/ _____

Parent/Guardian Signature Date Daytime Phone Number

******THIS FORM EXPIRES AT THE END OF THE SCHOOL YEAR****** **Updated: 11-Jun-21**