Covington Exempted Village School District

Administration of Over the Counter Medication at School

_____ Grade_____ Teacher _____

Student's Name

The above named student has parental/guardian permission for the following over the counter medication to be administered at school by designated personnel:

Medication _____

Dosage and time interval_____

_____ _____ _____

Parent/Guardian's Signature **Date** **Phone**

Permission will expire at the end of the current school year.

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A. I will assume responsibility for safe delivery of the medication to school. The medication must be received by the school in the original container in which it was dispensed.

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

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.

****Please Note:***

Parent/Guardian is responsible for providing the medication to the school.

Only necessary medication(s) will be administered during school hours.

Cough drops are considered Over the Counter Medication.