AUTHORIZATION FOR NONPRESCRIPED MEDICATION OR TREATMENT (SECONDARY VERSION)

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NON-PRESCRIBED MEDICATIONS IN SCHOOL. **ALL SPACES MUST BE COMPLETED**.

_____ _____
Name of Student Address

_____ _____
School Class/Grade

A. I am requesting permission for my child named above to:

[ ] Use or receive the following over- the-counter medication (s)

Medication: _____

Dosage: _____

Check Option 1 or 2 below.

[ ] Self administer such medications (s) in the presence of an authorized staff member.

[ ] keep the medication(s) in his/hers possession and self-administer the medication(s) as needed.

B. I 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 or the prescribed treatment.

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

_____ _____
Home Telephone Work Telephone

Authorization for Staff

The following staff members are authorized to administer the above- prescribed medication(s) / treatment(s):

_____

_____ _____
Principal