

AUTHORIZATION FOR NONPRESCRIBED 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