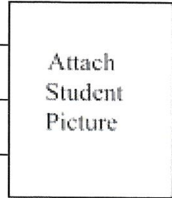
Old Trail School

Request to administer OTC (over the counter) medication



Student name:____DOB:___________Grade:_____

Address____City/State/Zip_____________________

Name of medication:____________________________**(One medication per form)** Dose:_________

Time to be given: ______________________________ (during school hours)

Reason for medication:____

Special Instructions: ____

Potential adverse reactions to be reported: ____

____

Physician's Name: _____________________________________ Phone: ___________________

Date to Begin Medication: **Date to End Medication:**

TO BE COMPLETED BY PARENT/GUARDIAN:

I give permission for my child to receive medication at school according to the School policy and agree to:

- Assume responsibility for safe delivery of the medication in original container to the school
- Notify the school immediately if there is any change in the use of this medication
- Have a new medication form completed if medication or dosage or instructions change

I hereby release from liability all school employees, the Board of Directors and School Health Services for damages or injury resulting from the use, misuse, or nonuse of such medication except as such Board, School Health Services or its employees are grossly negligent or engage in wanton or reckless misconduct.

______________________________________ _______________________

Parent's Printed Name Phone number

______________________________________ ____________________

Parent's Signature Date

Medication forms expire at the end of the school year.