AUTHORIZATION FOR NON-PRESCRIBED MEDICATION

To the Parent/Guardian:

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

_____ _____

Name of Student Date of Birth

_____ _____

School Grade/Teacher

_____ _____

Allergies Medical Concerns

A. I am giving permission for my child named above to use or receive the following over-the-counter medication(s) in the presence of an authorized staff member: (Check all that apply.)

Tylenol _____

Ibuprofen _____

Tums _____

Cough drops _____

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

C. I will be informed if requests for the above medication become excessive.

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/Guardian Date

_____ _____

Contact phone/cell numbers Work Phone