

TRIAD LOCAL SCHOOLS PARENT REQUEST AND AUTHORIZATION TO ADMINISTER
A NON-PRESCRIBED MEDICATION OR TREATMENT

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

Name of Student _____ Grade _____

Address: _____
Street Address City State Zip

A. I am requesting permission for my child named above to: (Check all that apply)

use or receive the following over-the-counter medication(s)

Medication: _____

Dosage: _____

Medication: _____

Dosage: _____

Medication: _____

Dosage: _____

self-administer such medication(s) in the presence of an authorized staff member.

B. I will assume responsibility for safe delivery of the medication to school. (The medication /drug must be received by the District (i.e. the person authorized to administer the drug to the student) in the container in which it was purchased.

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

D. I release and agree to hold the Triad 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: _____
Parent, guardian or other person having care or charge of the student:

Home Telephone: _____ Work Telephone: _____