

Permission for Over the Counter Medication

Student _____ Date of Birth _____

Allergies _____ Grade _____ Age _____

All over the counter medications provided by parent/guardian must be in their original, unopened container and be appropriate for the child's age and size. Medication will be given according to the directions on the container. Any over the counter medication (including cough drops) will be kept in the clinic until the end of the school year unless directed otherwise.

MEDICATIONS PROVIDED BY PARENT / GUARDIAN: Please list all medications that you will provide for your child:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

THIS AUTHORIZATION IS GOOD FOR ONE YEAR ONLY AND MUST BE RENEWED ANNUALLY. I (we) hereby give the school nurse, or person designated and trained to give the medication by the nurse, the authority to administer the above medication. I (we) shall hold harmless the Brownsburg Community School Corporation, its trustees, administrators, teachers and employees who may act in reliance upon the authority granted by us.

| | | |
|-----------------------------|---------------------------|--------|
| _____ | _____ | _____ |
| (parent/guardian signature) | (relationship to student) | (date) |

According to I.C. 20-34-3-18 and BCSC policy, as the parent/guardian of the student listed above, I give permission for the school to send the listed medication home with my child. I have explained to my child that the medication must remain in the sealed envelope and that it must stay in his/her backpack until he/she arrives home.

| | | |
|-----------------------------|---------------------------|--------|
| _____ | _____ | _____ |
| (parent/guardian signature) | (relationship to student) | (date) |