



Deer Park Community City Schools
AUTHORIZATION FOR NONPRESCRIBED MEDICATIONS

Form 5330 F1b

Student's Name

Date of Birth

School

Grade

School Year

Medication Allergies: Yes or No

If yes, please list: _____

PARENT/GUARDIAN:

The following information is necessary for any student to use nonprescribed medications in school.

Please complete all sections of the form and return the form to the school clinic for approval.

A. I am requesting permission for my child named above to:

[] Use or received the following over-the-counter medication(s):

Medication: _____

Dosage: _____

Frequency (How often): _____

Reason for administration: _____

All medication will be kept in the school clinic and administered by an authorized staff member.

B. I will assume responsibility for safe delivery of the medication to school.

The parent/guardian is responsible for providing the school with the medication unless it is one of the following medications routinely stocked in the school clinic for student use:

[] Acetaminophen 325 mg tablets

[] Ibuprofen 200 mg tablets

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

E. I am aware that this form is only valid for the current school year.

Signature of Parent/Guardian

Date

Home/Cell Phone

Work Phone

FOR CLINIC/SCHOOL NURSE ONLY:

Medication verified by: _____

Date: _____