AUTHORIZATION for "Over-The-Counter" (Non-prescription) Medication or Treatment

____ SHS ____ SMS ____ Glenford ____ Thornville _____ Somerset

1. Complete the following information.
2. Bring in medication in it's original container. (DO NOT place in baggie, etc.)
3. Do not exceed dosage as recommended by manufacturer.
4. Remember. Your child may NOT carry medications on their person.

Name of Student **Birthdate**

A. I am requesting permission for my child named above to use or receive the following over-the-counter medication (s). The student will self administer such medication in my presence or that of an authorized staff member.

☐ Ibuprofen (Motrin, Advil)
200mg
____1 tablet ____tsp
Every 4 to 6 hours if needed

☐ Tylenol (Acetaminophen)
325mg
___1 tablet ____tsp
Every 4 to 6 hours if needed

☐ Other _____
Dosage _____ mg
_____ ___tablets, ___caplets, ___capsules, or ____teaspoon(s)
Every _____ hours _____

☐ I have sent the above medication in the original bottle to be kept in the clinic for future use.

B. I will assume responibility for safe delivery of the medication to school.
C. I will notify the school immediately if there is any change in the use of the medication (s).
D. I release and agree to hold the Board of Education, it's officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent Date

Home Telephone Work Telephone

***NOTE: Please pick up all medications at the end of the school year. They will be destroyed if they are not picked up.

Revised 01/22/13