# WILLIAMSBURG COMMUNITY SCHOOL DISTRICT

## *AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION DURING SCHOOL HOURS*

My child, _____, must receive the following non-prescription medication during school hours. Medication will be sent in the original container with label clearly marked. I understand that the school nurse may call my physician if there is a question pertaining to the administration of the named medication.

Name of medication (s) _____

Dosage _____

Time to be administered _____

Termination Date _____

Purpose of Medication _____

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I hereby release, discharge and hold harmless the Williamsburg Community School District its agents and employees, from any all liability and claim whatsoever for the administration of the above medication to my child, for damages our child may suffer as a result of this request.

_____ _____

Date Signature of Parent/Guardian