FOLSOM CORDOVA UNIFIED SCHOOL DISTRICT HEALTH SERVICES

AUTHORIZATION FOR THE ADMINISTRATION OF NON-PRESCRIPTION OVER-THE-COUNTER MEDICATION IN SCHOOL

PLEASE NOTE: THIS FORM MUST BE COMPLETED EACH SCHOOL YEAR FOR EACH MEDICATION

Student's Name _____ Birthdate _____ Grade _____School _____

My child will need to take non-prescriptive, over-the-counter medication during school hours. I understand that non-prescription medication shall be brought to the school office in the original container(s) and labeled with my student's name.

We the undersigned, who are the parent(s)/guardian(s) of _____ request that non - prescriptive, over-the-counter medicine be administered to said child by a designated member of the school staff in accordance with the instructions outlined below.

I agree as soon as my child no longer needs to take this non-prescriptive, over- the- counter medication, I will notify the school and personally retrieve the medication from the school office.

In-agreeing to have the school administer our son's/daughter's over- the- counter medication I voluntarily agree to release, discharge, and hold harmless Folsom Cordova Unified School District and its officers, agents, and employees for any and all claims of liability arising out of their negligence, recklessness or any other act of omission which causes our child's illness, injury, death, and damages of any nature in any way connected with the administration of our child's medication.

We understand that the major responsibility for a child taking medication rests with the child and his/her parents/guardians, and that we are required to personally bring the medication to school (preschool through the 5th grade). We understand that students in grades 6 through 12 may bring their own to the school office.

Please note: School Nurses are not always present on the school campus. Whenever possible please administer over-the-counter medications outside of school hours. If over-the-counter medication must be administered during school hours, please complete the information below:

Diagnosis or indication for medication: _____

Medication: _____ Dosage: _____ Approximate time: _____

Method or route of administration: _____ Length of time to be taken: _____

Precautions (please note side effects of this medication): _____

Instructions: _____

Parent's/Guardian Signature: _____ **Date**: _____

Parent's name (please print): _____

Home Phone _____ Work Phone _____ Cell Phone _____

11-2019

Student's Name ____ School___________________ Grade ______

Medication ____ Dosage _________________________

Monday			Tuesday			Wednesday			Thursday			Friday		
Date	Time	Init.	Date	Time	Init.	Date	Time	Init.	Date	Time	Init.	Date	Time	Init.