

AUTHORIZATION FOR MEDICATION: Over-the-Counter Medication

Student's Name: _____ Date of Birth: _____

Home Address: _____

School: _____ Grade: _____ Class: _____

School Phone #: _____ School Fax#: _____

Allergies to Medication: _____

*Medication Name	*Dosage	*Route	*Frequency	*Reason for usage

PARENTAL PERMISSION FOR MEDICATION

My student has permission to have the above over-the-counter (non-prescribed) medication to be used during school hours, including when they are away from school property for official school events. I understand that the medication will be kept in the health office or with an authorized staff member when away from school property.. I give my permission for the over-the-counter medication to be administered by an employee of the Board who are licensed health professionals, or who have completed a drug administration training program conducted by a licensed health professional and are designated by the Board.

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.

NOTE:

- Medications must be provided and maintained in the original manufacturer's sealed packaging .
- It is your responsibility to notify the school when there is a change in medication regimen.
- This authorization is good for one school year only. A new authorization will be required each school year.

Parent / Guardian Name (Printed)

Signature of Parent / Guardian

Date Signed

Best Number(s) to be reached

District Nurse Approval _____

Date: _____

***Information required by ORC 3313.713 effective March 20, 2025**

