AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Name of Student _____ Address _____

School/ Grade/Teacher _____ Phone _____

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

. _____ receive the following over-the-counter medication/s or treatment or to self-administer such medication/s or treatment in my presence or that of an authorized staff member

Medication: _____

Dosage: _____

Medication: _____

Dosage: _____

B. ***I will bring the medication to school in its original unexpired container.***

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment by providing the physician's statement of change.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

E. The State of Ohio allows students to carry inhalers, Epipens, or emergency medication such as insulin if the prescriber feels that it is necessary for the student to carry the medication, has taught the student the proper use of the medication, and the student has demonstrated to the prescriber the proper use of the medication

Signature of Parent _____ Date _____

Home Telephone _____ Work Telephone _____

Administrator's Signature _____ Date _____
Or

District Nurse _____ Date _____

10/07