

Authorization for Non-Prescribed Medications/Cough Drops

To the parent/guardian:

The following information is necessary for any student to use non-prescribed medications in school.

All spaces must be completed.

STUDENT INFORMATION:

Name: _____ Address: _____

School: _____ Class/Grade: _____

MEDICATION INFORMATION:

Medication Name: _____

Dosage: _____

By signing this, I assume responsibility of safe delivery of the medication to the school and notifying the school immediately if there is any change in the use of the medication or the prescribed treatment. 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.

Parents/Guardian Signature: _____ Date: _____

Printed Name: _____

Home Telephone: _____ Work Telephone: _____

****NOTE:** The parents of the student must assume responsibility for informing the office of any changes in the student's health or any change in the prescribed medication. Any changes to the above will require completion of a new form. PARENTS MUST SEND MEDICATION TO SCHOOL IN ITS ORIGINAL CONTAINER (including box if applicable).

