



Kip Crain, Ph.D., Superintendent
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**AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT
(SECONDARY VERSION)**

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED. PLEASE PROVIDE THE SCHOOL WITH AN UNOPENED BOTTLE.

Name of Student

Address

School

Class/Grade

A. I am requesting permission for my child named above to use or receive the following over-the-counter medication(s).

Medication: Dosage: As directed on the bottle if anything more a License Prescriber statement must be completed. If less amount please indicate: _____

B. I will assume responsibility for safe delivery of the medication to school.

B. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

C. 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.

Signature of Parent

Date

Home Telephone

Work Telephone

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-non-prescribed medication(s)/treatment(s): Employees of the Board who are licensed health professionals or who have completed the district's drug administration training program.

Director
8/09 8/15/11
11/20/2015