PERMISSION FOR NON-PRESCRIPTION MEDICATION

Student_____ _____ Grade _____

Address _____ Date of Birth _____

TO BE COMPLETED BY PARENT:

Name of medication: _____ Dose_____

Time to be given: _____ (during school hours)

Reason for medication :_____

Form of medication:
____Tablet/capsule ____Liquid _____Other _____

Start date: _____ Stop date: _____

Special instructions: _____

Reactions to be reported to parent/physician: _____

Physician's name:_____ Phone: _____
Please print

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child to receive medication at school according to the school policy and as instructed by the parent and agree to:

- Assume responsibility for safe delivery of the medication to the school.
- Have a new form completed by the parent if medication or dosage is changed.
- Notify the school if there is a change in physician caring for this student.

Further, I hereby release from liability, and in addition agree to indemnify, all school employees and the Board of Education for damages or injury resulting from the use, misuse, or nonuse of such medication except as such Board or its employees are grossly negligent or engage in wanton or reckless misconduct.

Parent/guardian signature: _____Date _____

Daytime phone number _____

THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR

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