JEFFERSON LOCAL SCHOOL DISTRICT

AUTHORIZATION FOR NONPRESCRIPTION/OVER-THE-COUNTER MEDICATION

To the Parent:

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

Name of Student _____ Address _____

School _____ Grade _____

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

use or receive the following nonprescribed/over-the-counter medication(s).

Medication: _____

Dosage: _____

Check Option 1 or 2 below:

[ ] 1. have medication(s) administered by a designated district employee.

[ ] 2. self-administer such medication(s) in the presence of a designated district employee.

B. I will assume responsibility for safe delivery of the medication to school in its original container.

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

D. Our physician has instructed that this medication should be administered in the above designated dosage.

E. 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.

Signature of Parent _____ Date _____

Home Telephone _____ Work Telephone _____

Signature of School Representative _____ Date _____

THIS FORM WILL EXPIRE AT THE CONCLUSION OF THE CURRENT SCHOOL YEAR