Upper Sandusky Exempted Village Schools

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 Date of Birth

_____ _____

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: _____

Medication: _____

Dosage: _____

Medication(s) will be self-administered in the presence of a trained staff member.

B. I will assume responsibility for safe delivery of the medication to school in the original container with the child's name on it. All medications must be kept locked in the school office and not carried by the student or kept in a locker or backpack.

C. I will notify the school immediately if there is any change in the use of the medication or treatment. Any change will require a new authorization form to be completed.

D. 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.

_____ _____

Parent Signature Date

_____

Phone Number