USD 378

PERMISSION FOR ADMINISTRATION OF

OVER THE COUNTER MEDICATION AT SCHOOL

Please fill out all information below

Name of Student: ______________________________

School: ____________ **Grade:** ________ **Teacher:** ____________

Medication: ______________________________

Dosage: ______________________________

Date started: ______________ **Date stopped:** ______________

Time of day medication is to be given: ______________________________

Reason for medication: ______________________________

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I hereby give my permission for ____________________ to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I also understand that this medication will only be given on the days specified above and the medication will be sent home. I further understand that any school employee who administers any drug or nonprescription medication pursuant to parental written request to my student to accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse medication reaction suffered by the student because of administering such medication.

Signature of Parent/Guardian: ______________________________
Date__________

Note: **<u>If a "stop date" is not indicated, the medication will be sent home at the end of the day of the "start day".</u> The medication is to be brought to school in the original container. If the over-the-counter medication is prescribed by a physician, the medication must be appropriately label by the pharmacy or physician stating the name of the medication, the dosage and time to be given.**

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