

MEDINA CITY SCHOOLS

AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NON-PRESCRIBED MEDICATIONS OR TO RECEIVE NON-PRESCRIBED TREATMENT IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Name of Student

Address

School

Grade

A. I am requesting for my child named above to: (Check all that apply)

Use or receive non-prescription medications

Receive non-prescription treatment

Name of medication: _____

Dosage to be administered: _____

Time or intervals at which each dosage is to be administered: _____

Date the administration of medication is to begin: _____

Date the administration of medication is to cease: _____

Any severe adverse reactions that should be reported to the physician:

One or more telephone numbers at which the physician can be reached in an emergency:

Special instructions including sterile conditions and storage: _____

Name of Physician: _____

Address of Physician: _____

Date of this statement: _____

B. I will assume responsibility for safe delivery of the medication to school. The medication must be in its original container, labeled with the date. It must also be labeled with the student's name and exact dosage to be administered.

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

D. 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 Phone

Work Phone