Warren County Board of Education

Authorization/Parental Consent for Administering Over-the Counter Medication

Student's Last Name________________ First Name________________ MI______

Student Number________________ Grade________ Date of Birth____/____/____

Allergies____

Parental Consent

I am the parent or guardian of ________________. I give my permission for him/her to take the following over-the-medication (see below) for use when no nurse is available at the school site. I hereby acknowledge that I have read and understood the School Board Recommendations for distribution of medications to students. I hereby release________________ School and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

X________________________ ( )________________ ________________

Parent/Guardian Signature — Daytime Phone — Date

Over the counter medications can be given no more than 3 consecutive days without a physicians order. (09.2241.AP1)

Student Name: Last	First	MI	Age

Grade	Teacher

Reason student receiving medication

Name of medication	Dosage	Date to DC

Possible Reactions

Form of medication					
Tablet	Pill	Capsule	Liquid	Inhalant	Other

Feedback Required		
Yes	No	How often

____ ________________

Physician's Signature (if medication to stay at school over 3 days) — Date