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_____Homeroom/Classroom_____

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). I hereby acknowledge that I have read and understood the School Board Recommendations for distribution of medications to students. I hereby release the Warren County Board of Education 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 physician's order. (09.2241.AP1)

Student Name: Last	First	MI	Age
Name of Medication	Dosage	Time to Administer/How Often	
Reason Student Receiving Medication			
Form of Medication (please circle one) Tablet Pill Capsule Liquid Inhalant Other:			
Possible Reactions			
Feedback Required Yes No			

_____ _____

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