

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