Warren County Public Schools

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 counter 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 liabilities 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
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