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Kirtland Local Schools - Authorization For Non-Prescribed Medication

School Year: _____

The following information is necessary for any student to use non-prescribed medications in school.

STUDENT INFORMATION

_____	_____	_____	_____
Student Name	Birthdate	School	Grade

PARENT AUTHORIZATION

I am requesting permission for my child named above to use and receive the following over-the-counter medication(s).

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

I will assume responsibility for the safe delivery of the medication to school.

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

I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability, foreseeable or unforeseeable, for damages or injury resulting directly or indirectly from this authorization.

_____	_____	_____
Parent Signature	Date	Phone Number

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above non-prescribed medication(s): District Nurse, School Nurse, and authorized staff members who have completed a drug administration training program conducted by a licensed health professional.

_____	_____
District Nurse Signature	Date