AUTHORIZATION FOR "OVER THE COUNTER" MEDICATION

Joseph Badger School District
7119 State Route 7, Kinsman, Ohio 44428 Phone: 330-876-2800 Fax: 330-876-2811

Parent/Guardian,

The following information is necessary for any student to use Over the Counter medications or to receive treatment in school. All space must be completed.

_____ _____
(Name of Student) (Telephone)

_____ _____
(Address) (Date of Birth)

_____ _____
(School) (Room/Grade)

1. I am requesting permission for my child named above to: (check one or both)
   _____ use or receive medication
   _____ receive treatment

2. I am requesting permission for my child named above to receive the following over the counter medication at school: _____

3. I understand that the medication will be administered as instructed on the container unless otherwise indicated (specific instructions if different than instructions on the container): _____

4. I will personally be responsible for safe delivery of the medication to the school, for maintaining adequate amounts of medication, and replacing it prior to its expiration date

5. I will provide the school with a new authorization for if there is any change in the dosage or use of the medication, and I will notify the school in writing if I want the medication to be discontinued. I understand that verbal notification is permissible followed by written documentation by the next school day. Faxing the appropriate form is also acceptable.

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

_____ _____ _____
Signature of Parent/Guardian Relationship to Student Date

_____ _____ _____
Home Phone Work Phone Cell Phone