Willoughby-Eastlake City School District

AUTHORIZATION FOR NON-PRESCRIPTION (OVER THE COUNTER) MEDICATION

TO THE PARENT:

The following information is necessary for any student to use non-prescribed medications in school. All spaces must be completed.

Please use a separate form for each medication.

______________________________ ______________________________ ______________

Name of student School Class/Grade

____

Address Birthday

A. I am requesting permission for my child named above to:
(Check all that apply)

☐ Be administered the following over-the-counter medication by an authorized staff member.

Medication name: ____

Dosage: ____

Reason for medication: ____

☐ I give permission for my child to carry and self-administer cough drops provided from home.

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

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

D. 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.

______________________________ ______________________________

Signature of Parent Date

______________________________ ______________________________

Home Telephone Work/Cell

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above, non-prescribed medication.

____________________ ____________________ ____________________

____________________ ____________________ ____________________

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Principal

3/23/12