# OVER THE COUNTER MEDICATION FORM

Over the counter medication supplied by Parent/Guardian

Name of Student:____________________ Birthdate:_____________

Grade:_________ Homeroom Teacher:________________________

My child may take the medication listed below. I understand that non-medical school personnel may administer this medication. This authorization will be in effect for the current school year unless revoked in writing by the parent/guardian.

As parent/guardian, I have supplied the following over the counter medication for my child to take as needed. I understand that the school district maintains the right to restrict the use of this form for certain over the counter medications. Medications must be supplied in original packaging. All medications are to remain in the clinic, and are to be administered in the clinic.

***Frequent use MAY require a doctor's order- per nurse discretion***

Name of medication:________________________________________

***Directions will be followed as directed on the original packaging/ bottle to determine dose and frequency***

I, the parent/guardian of ___________________ hereby release Tri-County Local Schools, Board of Education, its officials and staff from any and all liability for damages or injury directly or indirectly resulting from my child's use of the over-the-counter medication.

_____________________________      ____________

Parent/ Guardian Signature      Date