BENJAMIN LOGAN LOCAL SCHOOL DISTRICT

AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Name of Student _____ Grade _____ Address _____

School Building _____

A. I am requesting permission for my child named above to: (Check one or both)

[ ] use or receive the following over-the-counter medication(s)

Medication _____

Dosage _____

Medication _____

Dosage _____

[ ] self-administer such medication(s) in the presence of an authorized staff member.

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 or the prescribed treatment.

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 Telephone _____

ONLY MEDICATION IN ITS ORIGINAL CONTAINER LABELED WITH THE DATE, THE STUDENT'S NAME, AND THE EXACT DOSAGE WILL BE ADMINISTERED.

PLEASE REMEMBER**:**

- You must provide the quantity of medication needed at school and necessary refills. You need to pick up any leftover medication within **1 week** after the end of the school year. Otherwise, the medication will be destroyed.
- A revised form must be provided if any information changes.
- Educate your child concerning proper administration techniques and time intervals as well as potential dangers and side effects associated with the medication.

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

_____

_____

Principal _____