Unified School District 273

OVER-THE-COUNTER MEDICATION

PARENT PERMISSION FORM

STUDENT NAME: _____ GRADE: _____

Please fill out this form for any over-the-counter medication you want given to your child

- Please indicate the medication, dosage, frequency, and dates to be given
- Medications must be in the **ORIGINAL CONTAINER**
- **PARENT / GUARDIAN SIGNATURE IS REQUIRED** in order to dispense over-the-counter medications

Form below must be filled out completely to be valid

MEDICATION	DOSAGE	WHEN TO GIVE DURING THE DAY	REASON FOR TAKING THE MEDICATION

Signature of parent / guardian required for medication to be dispensed

THE MEDICATION ABOVE MAY BE ADMINISTERED TO MY CHILD

_____ _____

(Signature of Parent or Guardian) **(Date)**

_____ _____

(Printed Name of Parent or Guardian) **(Phone)**

The above signature acknowledges that the school corporation and its employees assume no responsibility or liability for the prescription of medication, the dosage prescribed, or any consequences, directly or indirectly resulting from the administering of such medication in accordance with the instructions set forth above. The above signed further, both individually and as a parent and/or guardian of the above named child, does hereby waive and release any claim against the USD 273 or its employees resulting from the administering of such medication in accordance with the instructions set above.

For the School Nurse Only.

Received By: Date:

_____ _____