Melonie Queberg RN, BSN

MEDINA COUNTY CAREER CENTER

Authorization for the Administration of Over-The-Counter Medication by School Personnel

Student Name _______________ Date of Birth _______________

Address _______________

Student's Program _______________ Student's Instructor _______________ Grade _______________

PARENT/ GUARDIAN SECTION

We the undersigned request 'that the specified over-the-counter medication be administered to our child. We understand that the administration of this medication will be done under the supervision of a member of the school staff.

We further understand that the school personnel are not legally obligated to administer medication to any child. Therefore, we agree that the school district and its employees are free from any and all responsibility for the results of such medication or the manner in which it is administered.

We will notify the school immediately if we change or terminate the use of this medication for any reason.

Signature of Parent _______________ Date _______________

Home Phone Number _______________ Work Phone Number _______________

Medication must be provided in the original container (bottle). The dosage from the parent cannot exceed the dosage on the label.

Diagnosis for which medication is prescribed _______________

Medication _______________ Strength _______________ Dose _______________

Time Medication is to be Taken _______________ Administration Start Date _______________ Cease Date _______________

Instructions or precautions, including possible side effects and storage:

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