

Permission for Over the Counter Medications

**Medication to be administered for longer than a 2 week period
requires a physicians order.**

Name of Student _____

School _____ Grade _____

Teacher _____

Medication _____ Dosage _____

Date Started _____

Time of day medication is to be given _____

I hereby give my permission for _____ to take the
above medication at school as ordered. I understand that it is my
responsibility to furnish this medication. I further understand that any
school employee who administers any drug or nonprescription medication
pursuant to parental written request to my student in accordance with
written instructions from the physician or dentist shall not be liable for
damages as a result of an adverse medication reaction suffered by the
student because of administering such medication.

Date Signature of Parent or Guardian

NOTE: The medication is to be brought to school in the original
container appropriately labeled by the pharmacy, or physician, stating the
name of the medication, the dosage and times to be administered.