Niles Community Schools

AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT

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

Student Name: _____ Address: _____
Last First

School Attending: _____ Current Grade: _____ Date of Birth: _____

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. Our physician has instructed that this medication should be administered in the above designated dosage.

E. 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.

Parent/Guardian Signature: _____ Date: _____

Home Phone: _____ Cell Phone: _____

AUTHORIZATION FOR STAFF

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

_____

Principal Signature: _____ Date: _____

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