Name:_____

Teacher:_____

Grade:_____

The Ridgemont Local School District requires all of the following information before it will administer medication to this student.

Authorization for Administration of Over-The-Counter Medication Or Non-Prescribed

Parent Authorization for Over-The-Counter Medication

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

_____ use or receive the above prescribed medication (s)

Medication:_____

Dosage: _____ at the following time:_____

_____ self-administer such medication (s) in my presence or that 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/dosage.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from all authorization.

_____ _____

Signature of Parent Date

_____ _____

Home Telephone No. Work Telephone No.

*****ALL NON PRESCRIPTION MEDICATION MUST BE SENT IN ORIGINAL CONTAINERS. LIQUID COUGH MEDICINE IS PERFERED OVER COUGH DROPS WHENEVER POSSIBLE.*