PARENT'S AUTHORIZATION FOR THE ADMINISTRATION OF
NON-PRESCRIBED MEDICATION
BY SCHOOL PERSONNEL

Student Name________________________________ School____________________ Grade______

Address_____________________________________ Date of Birth__________ Date____________

TO BE COMPLETED BY PARENT / LEGAL CUSTODIAN / GUARDIAN / GRANDPARENT

*One Medication Per Form.

Name of Medication____

Time(s) to be given_____________________________________ (during school hours)

Time(s) to be given____ (non-school hours, field trips)

Dose ____

Form of Medication: ____Tablet/capsule ____ Liquid ____Inhaler ____Nebulizer ____Other

Start Date____________________________ Stop Date ______________________________

I give permission for my child to receive medication at school or on a field trip according to the District's Policy and as instructed by the prescribing physician and I agree to:

* Assume responsibility for safe delivery of the medication to the school.
* Have a new form completed by the physician if medication or dosage is changed.
* Notify the school of prescribing physician changes.
* Release and 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.

Date______________

Parent / Legal Custodian / Guardian / Grandparent Signature____________________________

Daytime Phone Number __________________

Fax to: Mogadore Jr High/High School 330-628-6657 / O.H. Somers Elementary 330-628-6662

This form will expire at the end of the school year