## AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT

To the Parent/Guardian:

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

________________________________________ ____________________

Name of Student Grade

I am requesting permission for my child named above to receive the following over-the-counter medication(s)

Medication: ______________________________________________

Dosage: ______________________________________________

Medication: ______________________________________________

Dosage: ______________________________________________

Parent/Guardian Initial Required:

_______ I will assume responsibility for safe delivery of the medication to school office.

_______ I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

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

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

________________________________________ ____________________

Signature of Parent/Guardian Date

________________________________________ ____________________

Home Telephone Work Telephone

The School City of Hobart does not discriminate on the basis of race, creed, sex, color, national origin, religion, age, sexual orientation, marital status, genetic information or disability, including limited English proficiency.

© NEOLA 2002

**OTC MEDICATION ADMINISTRATION LOG**
(To be completed for each medication)

**School Year** ____________________

**Name of Student** ________________________________________ **Sex**________ **Grade** _____________

**Name of Medication** ________________________________________________________ **Name of School**_________________________

**Dosage of Medication**_____________________________________ **Route(s)**____________

**Directions: Initial with time of administration; a complete signature and initials of each person administering mediations should be included below.**

| Date | Time | Dose | Reason | Initials | | Date | Time | Dose | Reason | Initials |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

**INITIAL** (of person administering medication)

| INITIAL | SIGNATURE | INITIAL | SIGNATURE |
|---|---|---|---|
| 1. ________ | ______________________ | 3. _______ | _________________________ |
| 2. ________ | ______________________ | 4. _______ | _________________________ |

© NEOLA 2006