PARENT REQUEST AND AUTHORIZATION
TO ADMINISTER OVER THE COUNTER MEDICINES

The following information is necessary for any student to use all medications or to receive treatment in school ALL SPACES MUST BE COMPLETED

Name of Student _____ Address _____

School _____ Grade _____

I am requesting that my child named above have the following over the counter medication administered by an authorized staff member. I will supply the medication in the original packaging.

MEDICATION _____

DOSAGE _____

HOW OFTEN _____

FOR THESE SYMPTOMS _____

-I will assume responsibility for safe delivery of the medication/drug to school. (The medication/drug must be received by the District (i.e., the person authorized to administer the drug to the student) in the container in which it was dispensed by the prescriber or a licensed pharmacist.)

-I will notify the school immediately if there is a change in the use of the medication/drug or the prescribed treatment. (You must submit to the District a revised licensed prescriber's statement, signed by the prescriber, if any of the information contained in the statement changes.)

-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.

Signature of Parent* _____ Date _____

Primary Telephone _____ Work Telephone _____

*Parent, guardian or other person having care or charge of the student.

Bethel Local Schools
Fax 845-0592
Attn: Clinic Aide