PINCONNING Area School District

AUTHORIZATION FOR **NON-PRESCRIBED** MEDICATIONS OR TREATMENT

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE **NON-PRESCRIBED** MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____ _____
Name of Student Address

_____ _____
School Grade

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.

_____ _____ _____
Signature of Parent Date Home/Work Telephone

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above **non-prescribed** medication(s)/treatment(s)

_____ _____

_____ _____

_____
Principal