Authorization for Administration of Over-the- Counter Medications at School

This form expires at the **end of the current school year**.

Grade Level: _____ Homeroom Teacher: _____

Student Name: _____

Street Address: _____ Apt. No: _____

City: _____ State: _____ Zip: _____

As this student's parent/guardian, I give permission for my child to receive the following medications during school hours. I agree to **provide the medication** my child needs in the *original labeled container with the protective seal intact.*

OTC medications are dispensed per package directions unless written directives are provided by a physician.

Circle yes or no for each medication listed below.

Over the Counter Medication	**Circle**	
Acetaminophen (Tylenol)	Yes	No
Ibuprofen	Yes	No
Anti-itch cream or lotion	Yes	No
Cough drops	Yes	No
tums	Yes	No
Silvadene Cream (burn cream)	Yes	No
Other:	Yes	No

Is the student allergic to any medications? _____No ____ Yes, allergic to _____

_____

I give permission to Hancock Public Health nurse or Liberty Benton Local Schools designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless the Hancock Public Health or Liberty Benton Local Schools and its agents from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information.

_____ _____

Signature of Parent/Guardian Date

_____

Parent/Guardian Name (Please Print)

How can we reach you during school hours?

_____ _____ _____

Work Phone Home Phone Cell Phone