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

This form expires at the end of the current school year.
All medications need to be picked up by the last day of school or it will be discarded.

Student Name: _____ Grade: _____

Street Address: _____ Homeroom Teacher: _____

_____

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.

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

Student Height: _____

Student Weight: _____

Is the student allergic to any medications?
NO_____
YES _____ (List medications): _____
_____

I give permission to the Liberty-Benton Local Schools nurse or designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless, 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

_____
Printed Name of Parent/Guardian

How can we reach you during school hours?
Home Phone: _____
Work Phone: _____
Cell Phone: _____