SHADYSIDE LOCAL SCHOOL DISTRICT

AUTHORIZATION FOR NONPRESCRIBED (OVER-THE COUNTER) MEDICATION OR TREATMENT
(PRESCHOOL – 6TH GRADE)

To the Parent / Guardian:

The following information is necessary for any student to use nonprescribed medication in school. All spaces must be completed.

______________________	______________________
Name of Student	Address
______________________	______________________
School	Grade

A. I am requesting permission for my child above to: (Check one or both)

_____ Use or receive the following over-the-counter medication

Medication: ______________________

Dosage: ______________________

How given (for example: by mouth): ______________________

Time to be administered or circumstances for use: ______________________

_____ Self-administer such medication in my presence or that of an authorized staff member.

B. I will assume responsibility of 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 treatment.

D. I release and agree to hold the Board of Education, 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	Date
______________________	______________________
Home Telephone	Work Telephone
______________________	
Cell Phone	

****Please provide the medication in the original container.** Any medication remaining at the end of the school year must be picked up by the parent, or it will be discarded.