Boyne Falls Public School

Authorization for Medication Administration Non-Prescription

Revised: 10-3-11

The following information is necessary for administration of NON-PRESCRIBED medications in school.

Student FULL Name: _____ Date: _____

Grade: _____ Date of Birth: _____ Student Age: _____

NON-PRESCRITION Medication Information

Name of Medication: _____

Purpose of Medication: _____

Dosage: _____ Frequency: _____

Notes About Medication (adverse reactions, precautions, etc.):

- I am requesting my child be administered his ***NON-PRESCRIBED*** medication at school by school personnel per the directions above. ***Check ONE:***
  - ☐ Use or receive the above over-the-counter medication.
  - ☐ Self-administer such medication in the presence of an authorized staff member.
  - ☐ Self-administer the medication and keep the medication in his/her possession.
- I will assume responsibility for safe delivery of the medication to school.
- I will notify the school immediately if there is any change in the use of the medication.
- Our physician has instructed that this medication should be administered in the above designated dosage.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____

Signature of Parent/Guardian Date

_____ _____

PRINT Name of Parent/Guardian DAYTIME Telephone