Authorization For OVER-THE-COUNTER Medication Or Treatment At School

IMPORTANT - The following information is necessary for any student to use over-the counter medications or treatments at school in accordance to the Negaunee Public School Board Policy and Handbook. This form must be fully completed and signed by the parent/guardian in order to administer any medication/treatment at school.

Student Name_____ **Grade** _____
Authorization is hereby given for the above named to receive or use the following over-the-counter medications or treatments.

1. Medication/Treatment: _____ Dose: _____ Administration Time: _____

Route: ☐Mouth (Oral) ☐Injection (Shot): ☐Subcutaneous ☐Intramuscular
☐Inhalation (Lungs) ☐Ear: ☐Left ☐Right ☐Peg Tube
☐Skin (Topical) ☐Nose: ☐Left ☐Right ☐Rectal
☐Eye: ☐Left ☐Right ☐Other: _____

Special Instruction: _____

Possible Side Effects: _____ Starting Date: _____ Ending Date: _____

* **FOR GRADES 9-12 ONLY:** Medication will be kept: ☐ With Student ☐In Front Office.

2. Medication/Treatment: _____ Dose: _____ Administration Time: _____

Route: ☐Mouth (Oral) ☐Injection (Shot): ☐Subcutaneous ☐Intramuscular
☐Inhalation (Lungs) ☐Ear: ☐Left ☐Right ☐Peg Tube
☐Skin (Topical) ☐Nose: ☐Left ☐Right ☐Rectal
☐Eye: ☐Left ☐Right ☐Other:_____

Special Instruction: _____

Possible Side Effects: _____ Starting Date: _____ Ending Date: _____

***FOR GRADES 9-12 ONLY**: Medication will be kept: ☐With Student ☐In Front Office.

SIGNATURE:

- I have discussed this with my physician and give permission for my child to receive the listed medication.
- I authorize school personnel to administer the listed medication, if necessary.
- 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 medication or treatment.
- I release and agree to hold the Board of Education, it's officials, and it's employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

➔**Parent Signature**: _____ **Date:** _____

Physician Name: _____ Phone:_____