WILMINGTON CITY SCHOOLS

AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT

To the Parent:

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

_____ Name of Student

_____ Address

_____ School

_____ Class/Grade

A. I am requesting permission for my child named above to take the following over-the-counter medication:

Medication: _____

Dosage: _____

I give permission for my child to: (Check one or both)

☐ use or receive above medication(s) administered by an authorized staff member.

☐ self-administer above medication(s) in the presence of an authorized staff member.

B. I will assume responsibility for safe delivery of the medication to school. I understand that medication must be sent in its original container, labeled with the student's name, and will be stored by the school. Students are NOT permitted to keep over-the-counter medications in their possession.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ Signature of Parent

_____ Date

_____ Home Telephone

_____ Work Telephone

WILMINGTON CITY SCHOOLS
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Wilmington, OH 45177
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