Howard-Suamico School District

Authorization to Administer

OTC MEDICATION

(Use a separate authorization form for each medication)

Student: _____ DOB: _____

School: _____ Grade: _____

FOR COMPLETION BY PARENT/GUARDIAN FOR OTC MEDICATIONS

Reason for medication: _____

Name of Medication: _____

Dosage: _____

Start date of medication: _____ Stop date of medication: _____

Administration: ☐ As needed: Indication for use: _____

If needed, how soon can administration of medication be repeated? _____

Medication cannot be repeated more then: _____

Side effects when contact should be made with you: _____

A. Parent must deliver the medication to school in its original container.
B. Parent will notify the school immediately if there is any change in the use of the medication.
C. 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.

Phone #1: _____

Phone #2: _____

Parent/Guardian Name _____

_____ _____

Parent/Guardian Signature: Date:

Parent: Return completed signed form to school office.