AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT
(ELEMENTARY VERSION)

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

Johnstown Middle School _____
School Grade

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

__X__ use or receive the following over-the-counter medication(s)

Medication: Cough Drop

Dosage: One as needed for cough; cough drops must be kept in the clinic

Medication: _____

Dosage: _____

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

B. I will assume responsibility for 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 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

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above-nonprescribed medication(s)/treatment(s): Staff who completed Board of Education approved medication administration training program and licensed medical staff.

_____
Principal