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 Monroe High 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: Acetaminophen 325mg tablet

Dosage: Adults & children 12 & older: Take 2 tablets every 4-6 hours as needed. Do not take more than 12 tablets in 24 hours.

Medication: Ibuprofen 200mg tablet. Adults & children 12 & older:

Dosage: 1 tablet every 4-6 hours while symptoms persist. If pain/fever does not respond to 1 tablet, 2 tablets may be used. Do not take more than 6 tablets in 24 hours.

_____ 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 have completed a Board of Education approved medication administration training program and licensed medical staff.

_____
Principal