

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 Elementary	
School	Grade

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

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

Medication: Cough Drop

Dosage: One as needed

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
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Home Telephone	Work Telephone
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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