Howard-Suamico School District

Authorization to Administer

OTCMEDICATION

(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.