



**AUTHORIZATION FOR NON-PRESCRIBED MEDICATION OR TREATMENT**  
**(Grades 6-12 SECONDARY VERSION)**

To the Parent:

The following information is necessary for any student to use non-prescribed medications in school. All spaces must be completed.

\_\_\_\_\_  
Name of Student

\_\_\_\_\_  
Address

\_\_\_\_\_  
School

\_\_\_\_\_  
Class/Grade

A. I am requesting permission for my child named above to use or receive the following over-the-counter medication.

Medication/Treatment: \_\_\_\_\_

Dosage: \_\_\_\_\_

Reason student needs to take medication (optional): \_\_\_\_\_

\_\_\_\_\_

Check option 1 or 2 below:

\_\_\_\_\_ My child will self-administer the medication in the presence of an authorized staff member.

\_\_\_\_\_ My child will keep the medication in his/her possession and self-administer the medication as needed.

B. I will supply the medication in the original container and 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.

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 Number

\_\_\_\_\_  
Work Telephone Number

\_\_\_\_\_  
Cell Telephone Number