KENSTON SCHOOLS

AUTHORIZATION FOR NON-PRESCRIBED MEDICATION OR TREATMENT
(Grades K-5 ELEMENTARY 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): _____

_____

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

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