School City of Hobart

AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT

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

_____ _____
School Grade

_____
Teacher

A. I am requesting permission for my child named above to receive the following over-the-counter medication(s)

Medication: _____

Dosage: _____

Time/s to be given_____

Medication: _____

Dosage: _____

Time/s to be given_____

B. I will assume responsibility for safe delivery of the medication to school office.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

D. Our physician has instructed that this medication should be administered in the above designated dosage.

E. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Signature of Parent Date

_____ _____
Home Telephone Work Telephone

The School City of Hobart does not discriminate on the basis of race, color, religion, gender, national origin, age, or individuals with disabilities, including limited English proficiency.