

Authorization for Non-prescription Medication

Cloverdale Community School Corporation requires that all of the following information be provided before it will administer medication or treatment to the student.

Name of Student

Date of Birth

School

Grade

I am requesting for my above named student to be given:

Medication:

Dose:

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

I understand that the school will not provide medication to my student if he/she runs out of the medication I have provided.

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

Our healthcare provider has instructed that this medication should be administered in the above designated dosage. (Please provide documentation from the provider.)

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

Parent/Guardian Signature

Date

Parent/Guardian Printed Name