LICKING VALLEY LOCAL SCHOOL DISTRICT
1379 LICKING VALLEY ROAD N.E.
NEWARK, OH 43055

NONPRESCRIBED (Over-the-Counter) MEDICATION AUTHORIZATION TO ADMINISTER OR ASSIST WITH MEDICATION OR TREATMENT

Scheduling of medication or treatment outside of school hours is encouraged. When that is not possible, this form must be completed every school year prior to school personnel dispensing medication or treatment. The **MEDICATION AND THIS FORM** is to be taken to the building principal and kept on file in the school office.

***To be Completed by Parent/Guardian**

Student's Name _____ Date of Birth_____

Student's Address _____

Name of Drug _____ Dosage _____

Route _____ Time_____

As parent/guardian of the above named child, my signature below authorizes the Principal, Nurse, or other responsible school personnel to administer, or assist with the medication or treatment to my child. I do assume responsibility for:

A. Safe delivery of medication in the **ORIGINAL DRUGSTORE CONTAINER** to the school office.

B. Instructing my child to present himself/herself and to take the medication at the scheduled time.

C. Understanding the medication will be destroyed at the end of this school year if not collected by parent/guardian.

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.

Parent/Guardian Signature _____ Date_____

Home Phone _____ Work Phone _____