LICKING VALLEY LOCAL SCHOOL DISTRICT
NONPRESCRIBED (over-the-counter) or PRESCRIBED MEDICATION
AUTHORIZATION TO ADMINISTER OR ASSIST WITH MEDICATION OR TREATMENT

I. 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 respective school office. **One medication per form.**

Student's Name: _____ **Date of Birth:** _____

Student's Address: _____

School/Grade/Teacher: _____

Non-Prescribed or Prescribed Medication/Treatment: _____

Dosage, Time, and Route: _____

For Asthma/Allergy/Diabetes Medication Management: is student able to self-carry? YES_____ NO_____

Is student independent and able to provide self-care? YES_____ NO_____

Instructions for Administration Including Storage and Sterile Requirements:

_____

Side Effects and/or Adverse Reactions to be reported to Parent and/or Physician: _____

_____

Beginning Date: _____ **Ending Date:** _____

II. As parent/guardian of the above named child, my signature below authorizes the Nurse or other school personnel that have completed medication administration training 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, or if the prescription ends.
D. I will notify the school immediately if there is any change in the use of the medication of the prescribed treatments.
E. I release and agree to hold the board of education, its officials, and its employees harmless from any and all liability foreseeable and unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature: _____ **Date:** _____ **Contact Number:** _____

****If prescribed, physician must fill-in below information and sign**

Prescriber's Printed/Typed Name: _____ Date:_____

Prescriber's Signature: _____ Prescriber's Phone Number: _____