NON-PRESCRIPTION DRUGS ADMINISTRATION TO STUDENTS

PARENTAL AUTHORIZATION AND RELEASE FORM

MILFORD EXEMPTED VILLAGE SCHOOL DISTRICT

Authorization form must be on file in the school clinic.

_____

STUDENT'S FULL NAME

_____ _____

GRADE **SCHOOL**

NAME OF MEDICATION	DOSE	FREQUENCY	BEGINNING DATE/END DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NOTE: USE OF THE NON-PRESCRIPTION DRUG IS NO MORE THAN 10 DAYS/DOSES WITHOUT A PHYSICIAN'S STATEMENT WITH THE EXCEPTION OF COUGH DROPS AND SUNCREEN (WHICH WILL BE MONITORED BY THE BUILDING HEALTH AIDE).

POSSIBLE ADVERSE REACTIONS:

_____

_____

I/We are the parent(s) and/or guardian in charge of: _____

STUDENT'S FULL NAME

I/We request that the Board of Education of the Milford Exempted Village School District, or its authorized representative, administer the above-named non-prescription drug to my child in accordance with my instructions above and agree to:

1. Submit this request to the person authorized by the Board to receive such request (building principal or assistant principal, school nurse, health aide, or in their absence, director of human resources);

2. Make sure personally that the non-prescription drug is received by the person authorized to administer it in the original container as purchased;

3. Submit a REVISED STATEMENT signed by parent or guardian to the person designated by the Board of Education to receive requests for administration IF ANY OF THE INFORMATION PROVIDED CHANGES;

4. Release the Board of Education of the Milford School District and their designated representative from any liability concerning the giving or non-giving of the non-prescription drug to the student.

_____

DATE

_____ _____

NAME OF STUDENT **TELEPHONE NUMBER(S)**

_____

PARENT/GUARDIAN SIGNATURE

Revised: April 20, 2017