OLENTANGY SCHOOLS℠

PARENT'S NON-PRESCRIPTION MEDICATION REQUEST FORM
(Grades 6-12 only)

Student's Name_____Grade Level _____

As a parent or legal guardian of the above named child, I am requesting that he/she be allowed to carry and self-administer an over-the-counter medication.

1. I have instructed the student as to the proper use of this medication.
2. I understand that students are not permitted to possess or carry more than a one-day supply of any over-the-counter medication.
3. 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 the damages or injury resulting directly or indirectly from this authorization.
4. I agree that this form is in effect for the duration of the current school year unless stated below.

SEE BELOW
_____
Dates medication to be taken

_____
Name of over-the-counter medication

_____ _____
Parent's Signature(s) Date Signed

Check all that apply. Use the blank lines for additional items.

- ___ acetaminophen
- ___ ibuprofen
- ___ anti-diarreahal/antacid
- ___ motion sickness medication
- ___ cough suppressant
- ___ cough drops
- ___ decongestant
- ___ allergy medication
- ___ laxative
- ___ _____
- ___ _____
- ___ _____
- ___ _____
- ___ _____