Oxford Community Schools

Parent/Guardian Authorization for Non-Prescribed Medication or Treatment

The following information is necessary for any student to use non-prescribed medications in school. All spaces must be completed.

Name of Student	**Address**
School	**Class/Grade**

I am requesting permission for my child named above to use or receive the following over-the-counter medication(s) or FDA approved topical substance:

Medication/ Topical Substance _____

Dosage _____

I give my child permission to (Check one):

- ☐ **S**elf-administer such medication(s) in the presence of an authorized staff member
- ☐ ***Secondary Students Only:*** Keep the medication(s) in his/her possession and self-administer the medication(s) as needed.

I will assume responsibility for safe delivery of the medication to school. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

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

Signature of Parent	**Date**
Home Telephone	**Work Telephone**

Authorization for Staff

The following staff members are authorized to administer the above-prescribed medication(s)/treatment(s):

_____

_____

_____

Principal's Signature / Date