SUGAR MAPLE NATURE SCHOOL
"Over the Counter" Medication Authorization
Parent/Guardian Form

Date_____

Student_____Date of Birth_____Grade_____

Medication Name_____

Dose_____

Time/Frequency_____

Duration (dates) of Administration: from_____to _____(limit of one school year)

Reason for the medication_____

Precautions, Interventions, Comments_____

- Medications must be brought into the school by a responsible adult in the original container.
- I give my permission to school personnel to give this medication to my child according to the preceding directions and to contact my child's physician if necessary.
- If this medication is injectable, school employees who have been trained in techniques of administering subcutaneous or intramuscular injections have my permission to administer it.
- I agree to hold the school district and personnel harmless in any claims arising from the administration of this medication at school.
- I agree to notify the school in writing when any change in the preceding orders is necessary.

_____

Parent/Guardian Signature Date

The School Nurse or any staff member trained to administer medication is authorized to administer this medication.

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School Administrator Signature Date