



SELF-ADMINISTER OVER-THE COUNTER MEDICATION FORM

As a parent or legal guardian of the child named below, I am requesting that he/she be allowed to carry and self-administer an over-the-counter medication. My signature below indicates that I agree to the following:

- I have instructed the student as to the proper use of this medication.
- Students are not permitted to possess or carry more than a one-day supply of any over-the-counter medication.
- The Board of Education or their designee reserves the right to deny or revoke permission for self-medication at any time.
- I release any claims against the Board of Education or its employee for allowing the below named student to self-administer medication(s) in accordance with this request.
- This form is in effect for the duration of the current school year unless stated below.

Student's name: _____

Student's grade: _____

Dates medication to be taken: _____

Name of over-the-counter medication: _____

Parent's signature: _____

Date: _____