AUTHORIZATION TO ADMINISTER OVER THE COUNTER MEDICATION IN SCHOOL

NAME OF STUDENT: _____

GRADE: _____

REASON TO ADMINISTER: _____

MEDICATION: _____

DOSAGE: _____

FREQUENCY: _____

SPECIAL INSTRUCTIONS: _____

I authorize the School Nurse, or in her absence, the Principal to administer the above medication as indicated. I understand and agree that the School, School Nurse and the Principal shall not be liable for any injury to the student resulting from the administration as authorized by my signature below.

_____

PARENTS SIGNATURE

_____

DATE