BETHANY SCHOOL NON CLINIC STOCK (Parent Provided)
OVER-THE-COUNTER MEDICATION AUTHORIZATION **School Year:** ________________
*****This order expires at the end of the school year*****

Medication provided by the parents must be in the original container with dosing information included.

One Medication Per Form

As this student's parent/guardian, I give permission for my child to receive the following over-the-counter medication during school hours or during after-school activities as indicated per package directions.

NAME OF STUDENT: ____ Homeroom ________
(please print)

DOB: ____________ WEIGHT: ________

Medication Allergies: YES/NO If yes, please list: ____

Name of Medication: ____ Dosage: ____________

Reason(s) for Medication to be Administered: ____

Time(s) of Administration: ________________ ________________ ________________

Special Instructions/reasons for medication: ____

____

____

Parent/Guardian or Designee (in event parent cannot be reached) **MUST BE** contacted prior to administration of medication? Yes No (circle one)

Comments: ____

____

I give permission to the Bethany School nurse or designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless Bethany School and its agents from all claims as a result of any and all acts performed under this authority. I will immediately notify the school in writing should my child develop any condition or begin taking medications which would preclude the safe administration of any of the above medications, or need to terminate the use of medication for any reason.

____ ________________________
(Signature of Parent/Guardian) Date

__________________________________ __________ ; __________________________________ __________

__________________________________ __________ ; __________________________________ __________

Please print name(s)/phone numbers above of parent(s)/guardian(s) or designees to contact if consent is required prior to administration of medication.