Lebanon High School
Grades 9-12 ONLY

Authorization of Non-prescribed (Over-the-counter) Medication

Each building will keep a supply of over-the-counter medication in the nurse's clinic.

My child may take the following medications at school (mark all that apply). The directions on the bottle will determine the dosage of each medication. This authorization will be in effect for the current school year unless revoked in writing by the parent/guardian. I hereby request and give my permission to the school RN, another Substitute RN, or trained personnel to administer the following over-the-counter medications to my child:

____ Acetaminophen
____ Antacids
____ Ibuprofen

___ Antibiotic Cream

____ Anti-itch cream
____ Cough Drops: (non-medicated)
____ Allergy/Allergic Reaction

Name of Student:_____

Address of Student:_____
_____

Name of School:_____

Student's Grade: _____ DOB:_____

We (I) understand that the administration of this medication is to be done under the supervision of the school nurse or designated non-medical personnel, assigned by the administrators. Further, we(I) understand that the school personnel are not legally obligated to administer any medication to a child, and therefore, we(I) agree to release and waive all claims against the School District and its employees from any and all bodily injury or death resulting from such medication or the manner in which it is administered. Further, we (I) will notify the school immediately if we (I) change medication or terminate the use of this medication for any reason.

Printed Parent/Guardian Name:_____Date:_____
Parent/Guardian Signature:_____
Primary Phone: _____ Secondary phone:_____

In Accordance with Board Policy 5330, Students are not permitted to carry, self-administer, or distribute/sell any type of Over-the-Counter medication. If you wish to have any other Non-prescribed medication given at school, please list it below and provide the Nurse's Office with a supply of the medication.

Disclaimer: The school district maintains the right to restrict the use of this form for certain Over-The-Counter medications.

Lebanon High School
Grades 9-12 ONLY
Administration Record For School Personnel Only

Medication	Date	Date	Date	Date	Date	Date	Date	Staff Initials

School RN, Substitute RN, Trained Personnel

Signature:_____ Initials:_____

Signature:_____ Initials:_____

Signature:_____ Initials:_____

Signature:_____ Initials:_____

Signature:_____ Initials:_____