Over the Counter Medication Authorization Form

A student's parent or legal guardian must complete this form with their student's information

Legal Last Name:_________________________ Legal First Name:________________________

Date of Birth:______________________________ Studio Level:___________________________

Reason for medication:____

Name of medication:____

Dosage:_________________ Time(s) of day to be administered: ________________________

How to be administered:____

Start date of medication:______________________ Stop date of medication:____________

Side effects of medication:____

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B. A Parent or Legal Guardian will notify the school in writing immediately and complete a new form if there is any change in the use of the medication.

I give NLPA personnel authorization to administer any medications as directed by this form. I release and agree to hold the School Board, the school, its officials, its employees, or agents harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

If medication dosage exceeds the amount listed on the box a doctors note must be attached. I have read the procedures outlined above and assume responsibility as required. I am aware that medications may be administered by a non- health professional.

Parent or Guardian's Signature:____________________________ Date: ________________

Parent's Telephone Number:(_____________)____