Heritage Christian School

Authorization for Over-the-Counter Medications

Grades 6-12

Parent/Guardian Permission

Name of Student: _____ Grade: _____

Medication: _____ Reason: _____

- I give permission to the Principal or his/her delegate (School Nurse or trained person) to administer over-the-counter medication to my child.
- I will assume the responsibility for the safe delivery of medication to school.
- I release and agree to hold the Board of Education, its officials and employees, harmless for any and all liability foreseeable or unforeseeable for damages/injury resulting directly or indirectly from this authorization.
- Medications will be kept locked in the designated medication cabinet.
- Authorizations must be updated yearly.
- I will notify the school immediately if there is a change in the use of medication.
- Medications must be in the original container with the original label as well as student name.

Parent/Guardian Signature: _____

Phone Number: _____ Date: _____

PARENT'S AUTHORIZATION TO GIVE MEDICATION

School Heritage Christian School Homeroom _____

I have read and understand the above agreement. I hereby request and give my permission for a

Heritage School staff member to administer _____ of _____
(# Of tablets) (Name of Drug)

at _____ to my child, _____. Childs birthdate: _____
(Time) (Childs Name)

Parent/Guardian's Signature: _____ Date: _____

Address _____ Home Phone _____

_____ Work Phone _____

Cell Phone _____