GreatHearts®
CLASSICAL EDUCATION. REVOLUTIONARY SCHOOLS.™

School Year:_____

MEDICATION AUTHORIZATION FORM – Non-prescription medications

STUDENT _____

Grade/Class _____ Birthdate _____ School year _____

Allergies (to medication) _____

*As the legal parent/guardian of the above-named student, I request the school to administer medicine for the following conditions. (*Circle all that apply*)*

REASON: **Headache** **Cramps** **Dental** **Other:** _____

MEDICATION NAME: _____ EXPIRATION: _____

Dose (must be within the recommended amount as stated on label): _____

Specify time _____ or As Needed _____ Frequency _____

**Medications are given during clinic hours (8:30am – 3:00pm) only.

All medications must be FDA approved.

Parent Statement:

I understand that the school is not legally obligated to administer medication to my child. Therefore, I agree to defend and hold harmless, the school district and its employees from any liability for the results of the medication or the manner in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements. Medication request must be deemed necessary to maintain or improve health and participation in the school program. Each request will be assessed for the most appropriate intervention and will be given at the standard dosage recommended by manufacturer.

- *I will notify the nurse if I give this medication to my child before arrival at school while this request is in effect to prevent overmedicating.*
- *I agree to supply medication for my student in its **original unopened packaging (small bottles only)**.*

Parent/Guardian Signature: _____Print Name: _____

Date Signed: _____ Phone number: _____

Nurse's Signature: _____