MAUMEE CITY SCHOOL DISTRICT

AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT ELEMENTARY STUDENTS **(K-5)**

FAX Numbers:	**Fairfield Elementary School**	**Fort Miami Elementary**	**Wayne Trial Elementary**
	419-891-5377	**419-891-5380**	**419-891-5378**

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

_____ _____
Name of Student Address

_____ _____
School Grade

A. I am requesting permission for my child named above to: (Check one or both)

_____ use or receive the following over-the-counter medication(s)

Medication: _____Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Medication: _____ Dosage: _____

Your child will be required to self-administer such medication(s) in my presence or that of an authorized staff member.

B. I will assume responsibility for safe delivery of the medication to school.

C. I will notify the school immediately if there is any change in the use of the medication or treatment.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

_____ _____
Signature of Parent Date

_____ _____
Home Telephone Work Telephone

7/98
10/10
5/15