WHITEHALL DISTRICT SCHOOLS

AUTHORIZATION FOR NON-PRESCRIBED MEDICATION OR TREATMENT

The following form is necessary for any student to use non-prescribed medication in school. Form must be completely filled out.

Student Name: ____ Birthdate: __________________

Address: ____

School building: ____ Grade: ____________________

I am requesting permission for my child named above to use or receive the following over-the-counter medication:

Medication Name: ____

Dosage amount: _______________________________________

Frequency to give: _____________________________________

An adult will assume the responsibility for safe delivery of the medication to school. The parent will notify the school immediately if there is any change in the use of the medication. The parent releases and agrees 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. Medication must be picked up by parent before the end of the school year or school personnel will dispose of.

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Parent / Guardian Name **(PLEASE PRINT)**

____ __________________

Parent / Guardian Signature Date

Contact Numbers: Home: _________________________________

Cell: ___________________________________

Work:_________________________________