Permission for Over-the-Counter Medication

Student Name: _____ Date: _____

Medication: _____

Dosage:_____

Complete this form to allow Madison Campus Elementary students to self–administer certain over-the-counter medications, such as Tylenol, Acetaminophen, Motrin, Advil, Ibuprofen, Midol, Aspirin, Antacid, and Cough & Throat lozenges. The student and parent will be responsible for the following:

1. Obtaining, reading, and signing this written permission form before the student is allowed to self-administer over-the-counter medications. Initial here: _____
2. Ensuring the medication must be in its original container and legibly labeled with the student's full name. Initial here: _____
3. Reminding the student, that he/she is not permitted to give his/her mediation to other students. Initial here: _____
4. Ensuring that Madison Campus Elementary has this signed permission on file. Initial here: _____

I hereby release and discharge and further agree to indemnify, hold harmless, or reimburse the School, its employees, agents, representative, and all other officials, from any and all claims, actions, and suits. Losses, costs, expenses, and liability in case of accident or any other mishap because of the negligence in administering such medication or because of side effects, illness, or any other injury which might occur to my child through administering such medication. And, I hereby release said aforementioned board, district, employees, and officials from any liability, suit, or claims of whatever nature and kind, which might arise as a result of administering the medication in accord with this request. I accept legal responsibility for my child should the above medication be lost, given, or taken by a person other than the above-named student. If this should happen, the privilege of carrying medication will be revoked. I further release the KY-TN Conference and its employees of any legal responsibility when the above student administers his/her own medication.

Signature of Parent/Guardian: _____ Date: _____

1. I understand how much and when to take the above-named medication. I will not allow another student to take my medication under any circumstance. Student Initial here: _____
2. I understand that I should self-administer (take) my over- the- counter medication in the presence of an MCE staff member to continue this privilege. Student initial here: _____

I have seen the above-labeled medication bottle(s) and have a copy of this permission form.

Parents/Guardians Signature: _____ Date: _____

Student Signature: _____ Date: _____