MOGADORE LOCAL SCHOOLS

PARENT'S AUTHORIZATION FOR THE ADMINISTRATION OF NON-PRESCRIBED MEDICATION BY SCHOOL PERSONNEL

Student Name________________________ School________________ Grade_____

Address__________________________ Date of Birth________ Date__________

TO BE COMPLETED BY PARENT / LEGAL CUSTODIAN / GUARDIAN / GRANDPARENT

*One Medication Per Form.

Name of Medication________________________________

Time(s) to be given__________________________ (during school hours)

Time(s) to be given__________________________ (non-school hours, field trips)

Dose ________________________________

Form of Medication: ____Tablet/capsule ____ Liquid ____Inhaler ____Nebulizer ____Other

Start Date____________________ Stop Date ____________________

I give permission for my child to receive medication at school or on a field trip according to the District's Policy and as instructed by the prescribing physician and I agree to:

* Assume responsibility for safe delivery of the medication to the school.
* Have a new form completed by the physician if medication or dosage is changed.
* Notify the school of prescribing physician changes.
* Release and hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Date____________

Parent / Legal Custodian / Guardian / Grandparent Signature____________________

Daytime Phone Number ______________

Fax to: Mogadore Jr High/High School 330-628-6657 / O.H. Somers Elementary 330-628-6662

This form will expire at the end of the school year