CARROLL COUNTY SCHOOL DISTRICT

Authorization/Parental Consent for Administering Over-the Counter Medication

(When no nurse is available at school)

Student's Last Name_____ First Name_____MI_____

Student Number_____ Grade_____ Date of Birth____/____/____

Allergies_____

Parental Consent

I am the parent or guardian of _____. I give my permission for him/her to take the following over-the-medication (see below) for use when no nurse is available at the school site. I hereby acknowledge that I have read and understood the School Board Recommendations for distribution of medications to students. I hereby release _____ School and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

X_____ (____)_____ _____

Parent/Guardian Signature | Daytime Phone | Date

Over the counter medications can be given no more than 3 consecutive days without a physicians order. (09.2241.AP1)

Student Name: Last	First	MI	Age

Grade	Teacher

Reason student receiving medication			
Name of medication		Dosage	Date to DC
Possible reactions			
Form of medication ☐ Tablet ☐ Pill ☐ Capsule ☐ Liquid ☐ Inhalant		☐ Other	
Feedback required ☐ Yes ☐ No		How often	

PLEASE NOTE: ANY MEDICATION NOT PICKED UP AFTER 3 CONSECUTIVE DAYS WILL IMMEDIATELY BE DISPOSED OF WITHOUT EXCEPTION.

If a student requires medication for more than 3 consecutive days please contact the health care provider to complete the Permission Form for Prescribed Medication.