

OLENTANGY SCHOOLS**PARENT'S NON-PRESCRIPTION MEDICATION REQUEST FORM
(Grades 6-12 only)**

Student's Name _____ Grade Level _____

As a parent or legal guardian of the above named child, I am requesting that he/she be allowed to carry and self-administer an over-the-counter medication.

1. I have instructed the student as to the proper use of this medication.
2. I understand that students are not permitted to possess or carry more than a one-day supply of any over-the-counter medication.
3. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for the damages or injury resulting directly or indirectly from this authorization.
4. I agree that this form is in effect for the duration of the current school year unless stated below.

Dates medication to be taken_____
Grade_____
Name of over-the-counter medication_____
Parent's Signature(s)_____
Date Signed_____
Parent's Signature(s)_____
Date Signed