Jackson County Board of Education

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 claim or liability connected with its reliance on this permission and agrees to indemnify, defend and hold them harmless from nay claim or liability connected with such reliance.

_____ _____ _____

Parent/Guardian Signature Daytime Phone Date

Over the counter medications can be given no more than 3 consecutive days without a physician's order.

Student Name: Last	First	MI
Age	Grade	Teacher
Reason student receiving medication		
Name of medication		
Possible reactions		
Form of medication Tablet_____ Pill_____ Capsule_____ Liquid_____ Inhalant_____ Other_____		
Feedback required Yes_____ No_____		

Acetaminophen a non-aspirin extra strength 500mg is the medication we have here at school to give the students. It is a pain medication; a generic Tylenol.