



WORTHINGTON SCHOOLS OVER THE COUNTER (OTC) PARENT PERMISSION FORM FOR NON-PRESCRIPTION MEDICATIONS

THIS FORM MUST BE ON FILE IN THE HEALTH OFFICE

Name of Student: _____

Date of Birth: _____

School: _____

Grade: _____

Medication(s): _____

Dosage: _____

Time/Frequency to Be Taken: _____

Check option below:

Option 1 (Grades PK – 12):

- ☐ As a parent or legal guardian of the PK-12 grade student named above, I am requesting that he/she/they be allowed to take an over the counter (OTC) medication administered by the school nurse or nurse's designee.

Option 2 (Grades 6-12 only):

- ☐ As a parent or legal guardian of the 6-12 grade student named above, I am requesting that he/she/they be allowed to carry and self-administer an over the counter (OTC) medication during school hours.
- My signature below indicates the following:
 - I have instructed the student as to the proper use of this medication.
 - Grade 6-12 students are not permitted to possess or carry more than one week's supply of any OTC medication during school hours.
 - The Board of Education or their designee reserves the right to deny or revoke permission for self-medication at any time.
 - I release any claims against the Board of Education or its employees for allowing the student named below to self-administer medications(s) in accordance with this request.
 - I will assume responsibility for the safe transport of the medication to school in its original labeled container. All medications must be kept in the original container.

DATE

PARENT/GUARDIAN SIGNATURE

HOME PHONE

WK/CELL PHONE

◆◆ **MEDICATIONS MUST BE SUPPLIED BY THE PARENT** ◆◆

◆◆ **THE NURSE DOES NOT SUPPLY ANY MEDICATIONS FOR THE STUDENT** ◆◆