

**PARENT REQUEST FORM  
FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATION BY SCHOOL  
PERSONNEL  
(USE BLACK INK)**

Only those medications that are medically necessary during school hours for a student's attendance or written in an IEP should be sent to school. Persons who may assist your child with medications include the school nurse (RN) and trained school staff. The parent/guardian must give a written request. The medication must be in the original container and properly labeled with student's first and last name. This form is good for one school year and must be renewed yearly.

THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION/ILLNESS MAY NOT BE GIVEN AT SCHOOL.

NOTE: A physician authorization form must accompany all prescription medication brought to school.

**OVER-THE-COUNTER MEDICATIONS NEEDED LONGER THAN TWO WEEKS MUST HAVE REVIEW AND APPROVAL OF THE SCHOOL NURSE AND MAY REQUIRE A PHYSICIAN'S ORDER.**

I am the parent/guardian of the child named below and I am acting on my own behalf and on behalf of this minor child. We hereby authorize and agree to hold the Avon Community School Corporation and its officers and employees harmless for the administration of the following medication.

NAME OF STUDENT: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

\_\_\_\_\_ (Hand written on a non-prescription container.)

TEACHER: \_\_\_\_\_ GRADE: \_\_\_\_\_

NAME OF MEDICATION & STRENGTH: \_\_\_\_\_

DOSAGE (amount): \_\_\_\_\_

TIME TO BE GIVEN AT SCHOOL: \_\_\_\_\_

REASON OR HEALTH PROBLEM: \_\_\_\_\_

MEDICATION TO BE GIVEN FROM: \_\_\_\_\_ TO: \_\_\_\_\_  
(Date) (Date)

HOW IT IS TAKEN: \_\_\_\_\_  
(Example: by mouth, by inhaler, with food or after meals)

WHEN WAS THE FIRST DOSE OF THIS MEDICATION GIVEN? \_\_\_\_\_

I understand that an Avon Community School Corporation employee or staff member administering medication in accord with the permission statement and the Avon Community School Corporation shall be immune from all liability for acts arising out of the administration of medication in accord with the terms of this document, except in the case of gross negligence or willful and wanton misconduct.

In addition to the immunity described above, in exchange for Avon Community School Corporation's agreement to assume responsibility for the administration of medication as described in this permission statement, we hereby release any and all claims that we may lawfully release at this time for acts or omission arising out of the administration in accord with this grant of permission.

\_\_\_\_\_  
PARENT'S/GUARDIAN'S SIGNATURE DAYTIME PHONE  
DATE \_\_\_\_\_

Reviewed by RN: _____ (Date)	Staff ____ may/____ may not administer
_____ RN (Print Name)	_____ RN SIGNATURE