## Harrison County School Health Clinic

**Authorization/Parental Consent for Administrating Over-the-Counter Medication brought from home and Short Term Medications (antibiotics, etc)**

**School:**_____ **School Year:** _____ **Date form received:**_____

**I acknowledge receipt of this Parent Authorization:**_____

Student's Last Name: _____ First Name: _____ MI: _____

DOB: _____ Grade: _____ Teacher:_____ Allergies:_____

Parental Consent:

I am the parent or guardian of _____. I give my permission for him/her to take the following over the counter/short term medication (see below). I acknowledge that I have read and understand the policy in place regarding administration for over the counter/short term medications in the school setting and wish my child to take the medication as described below. I release the **Harrison County School Board** 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.

_____ _____ _____

Signature of Parent/Guardian Day Time Phone Number Date

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

Reason Student Receiving Medication: _____

_____

Name of Medication: _____

Dosage:_____ Frequency:_____

Date to Start Medication: _____ Date to Stop Medication:_____

Student should be given medication only when exhibiting the following symptoms:_____

_____

_____

Possible Reactions or Side Effects:

Form of Medication: □Tablet/Pill/Capsule □Liquid □ Eye drops □Nasal drops □Inhalant □ Topical □ Other _____

Feedback Required/Requested : □ YES □ NO

How Often: □Note to be sent home at end of day

□Telephone call at the time medication is requested by the student

Other Notes or Specific information parent wants to know:

_____

_____

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