Akron Children's Hospital
School Health Services

Non-Prescription Medication Administered at School

School Year: _____

To Be Completed by Parent/Guardian:

Student: _____ D.O.B.: _____

School: _____ Grade/Class: _____

Name of Medication: _____ Dose: _____

Time to be given (during school hours): _____

Reason for Medication: _____

Form of Medication: _____Tablet _____ Liquid _____ Inhaler _____Nebulizer _____ Other

Start date: _____ Stop date: _____

Special Instructions: _____

Reactions to be reported to parent or doctor: _____

Doctor's Name: _____ Phone: _____
Printed Name

I give permission for my child to receive medication at school according to the school district policy and agree to:

- Assume responsibility for safe delivery of the medication in its original container to the school
- Have a new medication form completed if dosage or instructions change
- Notify the school of changes in healthcare provider

I hereby release from liability, and in addition agree to indemnify, all school employees, the Board of Education and School Health Services for damages or injury resulting from the use, misuse or nonuse of such medication except as such Board, School Health Services or its employees are grossly negligent or engage in wanton or reckless misconduct.

Parent/Guardian Signature: _____ Date: _____

Daytime Phone Number: _____

****THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR****

Rev 7/09

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School: Grade/Ciass: Mm

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