OVER-THE-COUNTER MEDICATION

PARENT PERMISSION FORM

2021-2022

Student Name _____ Grade _____ Teacher _____

- Please fill out this form for any over-the-counter medication you want given to your child
- Please indicate the medication, dosage, frequency, and dates to be given
- Medications must be in the **ORIGINAL CONTAINER**
- **STUDENTS MAY NOT**
  - **BRING MEDICATIONS TO SCHOOL OR**
  - **CARRY MEDICATIONS HOME FROM SCHOOL.**
- Medications must be transported to and from school by parent / guardian
- **PARENT / GUARDIAN SIGNATURE IS REQUIRED** in order to dispense over-the-counter medications

Form below must be filled out completely to be valid

Medication	Dosage	When to give during day	Reason for taking the medication	Dates to be given

Signature of parent / guardian required for medication to be dispensed

THE MEDICATIONS INDICATED ABOVE MAY BE ADMINISTERED TO MY CHILD

_____ _____

(Signature of Parent/ Guardian) (Date)

The above signature acknowledges that the school corporation and its employees assume no responsibility or liability for the prescription of medication, the dosage prescribed, or any consequences, directly or indirectly resulting from the administering of such medication in accordance with the instructions set forth above. The above signed further, both individually and as a parent and/or guardian of the above named child, does hereby waive and release any claim against the West Lafayette Community School Corporation or its employees resulting from the administering of such medication in accordance with the instructions set above.

_____ _____

School Nurse Date received by Nurse

West Lafayette Community School Corporation, 1130 North Salisbury Street, West Lafayette, IN 47906

West Lafayette Elementary
Nurse: (765) 269 - 4105
Fax: (765) 464 - 3210

West Lafayette Intermediate
Nurse: (765) 269-4304
Fax: (765) 405-7038

WL Jr / Sr High School
Nurse: (765) 746 - 0419
Fax: (765) 746 - 0422