PRYOR PUBLIC SCHOOLS

NON PRESCRIPTION MEDICATIONS- NO PHYSICIAN SIGNATURE REQUIRED

NAME OF CHILD: _____ **DOB:** _____ **SCHOOL:** _____ **GRADE:** _____

SCHOOL YEAR _____ **TEACHER (if applicable):** _____

DIAGNOSIS	**MEDICATION**	**TIME:**	**DOSAGE:**	**START DATE:** **END DATE:**
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* The initial dose must be given at home.
* Non-prescription (over-the-counter) medication must be furnished in the original container from the manufacturer
* Medication to be stored as directed by school nursing staff.
* Parent/guardian is responsible for supplying medication. Medication should be given in accordance with manufacturer age and dosage guidelines.
* Student has demonstrated to me that he/she/they understand(s) the proper use of this medication
* I acknowledge that the school district may not incur liability as a result of any injury arising from the self-administration of medication by the pupil, and that I shall indemnify and hold harmless the school district and its employees and agents against any claims except a claim based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort
* I understand that it is my responsibility to pick up any unused medication at the end of the school year, and that medication not picked up will be disposed of.
* I request that the principal or his/her/their designee allow my child to take the medication as directed above
* I understand this form is valid during the current school year and summer school if needed.

Parent/Guardian Signature: _____ **Date:** _____

Telephone Number: _____

HOME **WORK** **CELL/EMERGENCY**