Holly Area Schools

Parent/Guardian Permission for Over-The-Counter (OTC) FDA Approved Medication

(This form is for lotions, creams, sunscreen and cough drops only).
(OTC medication requires a physician authorization form. Medication **must** be ordered by a physician).

Student's Name: _____ School Year: _____

Date of Birth: _____ School/Program: _____

Age: _____ Grade: _____ Teacher: _____

Parent:

- I am requesting permission for my child named above to: (Check one or both)

  _____ Use (Self administered)
  _____ Receive assistance applying the following over-the-counter medication(s)

  Medication: _____ Dose: _____

  Route or Location: _____ Frequency: _____

  Reason for use: _____

Medication will <u>ONLY</u> be given per manufacturer recommended guidelines

- I will assume responsibility for safe delivery of the medication in the original, unopened and not expired container to school.
- I will notify the school immediately if there is any change in the use or prescribed treatment of the medication.
- I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable and unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Signature of Parent: _____ Date: _____

Phone (1): _____ Phone (2): _____

***This form is only valid for one school year.**