

## Non-Prescription Medication Self-Administration Form

*To Be Completed by Parent/Guardian:*

Student's Name:		Birth Date:
Address:		
Emergency Phone:		Grade:
Name of Non-Prescriptive Med.	Dosage of Medication (i.e., mg., ml., etc.)	Frequency

I hereby authorize my student, \_\_\_\_\_, to self-administer the above listed non-prescription medication(s). I understand my student must take the above listed non-prescription medication(s) in the Health Office and should not take the non-prescription medication anywhere else in the school. Taking medications outside the Health Office may result in disciplinary action. I authorize the school nurse to oversee my student's self-administration of the above listed non-prescription medication(s).

**After-School Events/Extracurricular Activities:**

In the event that my student is involved in an after-school athletic or extracurricular activity, I authorize the following coach(s)/program director(s) to oversee my student's self-administration of the above listed non-prescription medication(s) at the after school activity.

Coach/Director Name: \_\_\_\_\_

Coach/Director Name: \_\_\_\_\_

I agree to waive any claims I might have against District 201, its employees and agents arising out of the student's self-administration of the above listed non-prescription medication(s). In addition, I agree to hold harmless and indemnify District 201, its employees and agents, either jointly or separately, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the self-administration of the above non-prescription medication(s).

Parent/Guardian Name:	
Please print:	
Parent/Guardian Signature:	Date: