Cleveland Heights-University Heights City Schools
Department of Student Services

Nurse's Office

PARENT PERMISSION FOR NON-PRESCRIPTION MEDICATIONS (OVER THE COUNTER)

Student's Name: _____ ID:_____ DOB: _____

I/We accept the responsibility, consequences and risks in school to my/our child and other children as a result of the self/assisted-administered non-prescribed medication.

The request for self/assisted-administered non-prescribed medication will be renewed by the parent(s) or guardian(s) and reviewed by the school nurse at the beginning of **each school year**.

This medication will be for the **exclusive use** of the named student.

This medication will be transported to school in the **original container**.

The Board of Education of the Cleveland Heights – University Heights Schools and any of its employees will not be responsible for any liability as a result of the self/assisted-administered non-prescribed medication.

Name of medication(s): _____

Dosage of medication(s): _____

Reason for medication: _____

Times medication(s) to be taken: _____ OR ☐ as needed & per label instructions

Length of time medication is to be taken: UNTIL _____ OR ☐ end of school year

Signed: _____
(Parent/Guardian Signature)

Daytime phone number: _____

Date: _____