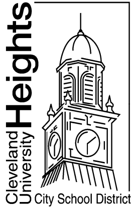

CHHS revision of form 09f 2/06

Cleveland Heights-University Heights City Schools
Department of Student Services

Nurse's Office

PARENT PERMISSION FOR SELF/ASSISTED- ADMINISTERED NON-PRESCRIBED MEDICATION

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**.

When possible the medication brought to school will be a single daily dosage (contact the building nurse for acceptable exemptions).

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: ____

Length of time medication is to be taken: ____

Signed: ____
(Parent/Guardian Signature)

Daytime phone number: ____

Date: ____

Physician's Name: ____

Telephone Number: ____