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-administered non-prescribed medication.

The request for self-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.

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-administered non-prescribed medication.

Name of medication(s): _____

Dosage of medication(s): _____

Times medication(s) to be taken: _____

Length of time medication is to be taken: _____

Reason for medication: _____

_____

Signed: _____
(Parent/Guardian Signature)

Daytime phone number: _____

Date: _____

Physician's Name: _____

Address: _____

Telephone Number: _____

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