Badin High School

Phone: 513-863-3993

Fax: 513-785-2844

Over - the - Counter Medication Permit

I request and give my permission to the principal or his/her designee (school nurse or other responsible person) to administer the following medication to my child.

Student's name: _____ DOB:_____

Name of medication: _____ Grade:_____

dosage: _____ *or* Number of tablets: _____ route: _____

Give at the following time(s):_____

Specific instructions for administration: _____

_____

Possible side effects to watch for and what steps should be taken if side effects occur:

_____

As the parent / guardian of the student listed above, I release, and agree to hold the AOC, Board of Education, its officials, and its employees harmless from any and all liability foreseeable, unforeseeable for damages or injury resulting directly or indirectly from this authorization. *(Permit Expires End of School year)*

_____ _____

Parent / Guardian Signature Date

_____

Parent / Guardian Print Name

_____

Parent / Guardian Phone Number

_____ _____

Nurse Signature Date Principal Signature Date

AOC Policy 9/2021

MAS