FERNDALE AREA SCHOOL DISTRICT

AUTHORIZATION FOR NON-PRESCRIPTION MEDICATION DURING SCHOOL HOURS

My child/ward _____ must receive the following NON_PRESCIPTION medication during school hours.

Name of non-prescription medication_____

Time schedule_____

Dosage_____

Reason for administration_____

_____

I do hereby release, discharge, and hold harmless the Ferndale Area School District, its agents, and employees, from any and all liability and claim whatsoever for the administration of the above medication to my child/ward should there develop an allergic or any other reaction from the medication.

_____ _____ _____
Parent/Guardian Signature Date Telephone

_____ _____ _____
Parent/Guardian Signature Date Telephone