SARASOTA
CHRISTIAN SCHOOL

Over-the-Counter Medication Authorization

Student Name_____ Grade_____

Allergies_____ School Year 2018-19

I grant permission to the superintendent or his designee to assist in the administration of over-the-counter medication to my child while in school and while participating in field trips. I will supply the named medication in an unopened, original store-issued container. I understand that is it my responsibility to hand carry medication to the school health room (**do not send medication to school with your child**). I understand that this agreement is valid until I terminate permission or until the end of the current school year. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

Name of Medication (brand, strength):_____

Instructions to administer:_____

_____

_____

_____

Amount: _____ Frequency: _____ Time: _____ Duration: _____

Parent/Guardian Name: _____

Home Phone: : _____ Cell Phone: _____

Parent/Guardian Signature: _____ Date: _____