FRIEND PUBLIC SCHOOL
PARENT AUTHORIZATION TO ADMINISTER MEDICATION

TO: FRIEND PUBLIC SCHOOL

I AM THE PARENT WITH LEGAL CUSTODY OR THE LEGAL GUARDIAN OF ________________________________, A STUDENT ATTENDING THIS SCHOOL. THIS STUDENT MAY REQUIRE MEDICATION AT INTERVALS DURING THE SCHOOL DAY. I AM SUPPLYING EITHER THE OVER-THE-COUNTER OR PRESCRIPTION MEDICATION, IN THE ORIGINAL CONTAINER, WITH THE STUDENT'S NAME AND INSTRUCTIONS CLEARLY MARKED.

I HEREBY AUTHORIZE AND GIVE MY CONSENT TO THE SCHOOL OFFICIAL OR OTHER DESIGNATED SCHOOL EMPLOYEE TO:

> ADMINISTER ACETAMINOPHEN (TYLENOL), IBUPROFEN (ADVIL), AND OTHER OVER-THE-COUNTER MEDICINES (NO ASPIRIN). I ALSO AUTHORIZE A FILLED PRESCRIPTION MEDICATION, WHICH I AM SUPPLYING, IN ACCORDANCE WITH THE DIRECTIONS, TO BE ADMINISTERED AS LISTED ON THE PRESCRIPTION LABEL ON THE CONTAINER.

I UNDERSTAND THAT UNDER STATE LAW THE BOARD OF EDUCATION, THE FRIEND SCHOOL DISTRICT OR THE EMPLOYEES OF FRIEND SCHOOL DISTRICT SHALL NOT BE LIABLE IN THE ADMINISTERING OR OMISSIONS OF THE MEDICATION I HAVE AUTHORIZED.

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PARENT WITH LEGAL CUSTODY

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DATE