Authorization for Non-Prescribed Medication or Treatment

The following information is necessary for any student to use non-prescribed medications at the Academy. All spaces must be completed.

Name of Student	Address
Grade	Parent Telephone

A. I am requesting permission for my child named above to: (Check all that apply)

_____ Use or receive the following over-the-counter medicine(s)

Medication: _____
Dosage: _____

B. Please check option 1 or 2 below:

_____ 1. Self-administer medication(s) in the presence of an authorized staff member

_____ 2. Keep the medication(s) in his/her possession and self-administer as needed.

I will assume responsibility for safe delivery of the medication to the school. I will notify the school immediately if there is any change in the use of the medication or treatment.

It is my understanding that the Academy has taken every precaution to safeguard my child. I release and agree to hold the Academy, its Board members, staff, volunteers, and agents harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from the administration of the medication/treatment.

I also agree to defend, indemnify, and hold harmless the Academy, its Board members, staff, volunteers and agents from and against any such claims, demands, suits, damages, liability, costs, and expenses (including reasonable attorney fees) incurred as a consequence either directly or indirectly of the granting of this authorization to administer the medication/treatment.

Signature of Parent	Date
Home/Cell phone	Work Phone