Madison Local School District
MES Phone (513) 420-4755, Fax (513) 420-4915
MMS Phone (513) 420-4916, Fax (513) 420-4990
MHS Phone (513) 420-4760, Fax (513) 420-4914

AUTHORIZATION FOR NONPRESCRIBED MEDICATION OR TREATMENT

This form expires at the end of the current school year.

To the Parent:

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED. ALL OVER-THE-COUNTER MEDICATIONS MUST BE PROVIDED BY THE PARENT/GUARDIAN. AN ADULT MUST BRING THE MEDICATON TO THE SCHOOL.

Name of Student_____ Birth Date_____

Student's Address_____
Street City Zip Code

School_____ Class/Grade_____

A. I am requesting permission for my child named above to take the following over-the-counter medication(s):

Circle YES or NO for each medication listed below:

Medication	Circle One		Dosage
Acetaminophen (Tylenol) for headache, toothache or minor pain	Yes	No	
Ibuprofen for headache, toothache, minor pain or menstrual cramps	Yes	No	
Anti-itch cream or lotion	Yes	No	[redacted]
Cough Drops	Yes	No	
Antacid (Tums)	Yes	No	
Antibiotic Ointment	Yes	No	[redacted]
Other:	Yes	No	

B. I will assume responsibility for safe delivery of the medication to school.
C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Signature_____ Date_____

Phone number(s) during school hours_____

Email address_____