MORAGA SCHOOL DISTRICT
SCHOOL MEDICATION AUTHORIZATION FORM

PERMISSION TO ADMINISTER OVER THE COUNTER (OTC) MEDICATION

MEDICATION DURING SCHOOL HOURS
This form must be completed by the parent/guardian and contain their signatures before any medication can be administered at school. THE PARENT OR ADULT REPRESENTATIVE MUST BRING ALL MEDICATIONS TO SCHOOL IN THE ORIGINAL CONTAINER.

I give permission for my child to receive over-the-counter (OTC) medication at school from the types listed on the attached page. I, or an adult representative whom I designate, will bring all OTC medication to school in its original container. I understand the dosage to be administered will not exceed the dosage recommended on the container unless an increased dosage is approved in writing by my child's physician. I understand additional OTC medications that are not on the list must be approved in writing by a physician before they can be administered to my child. I agree to, and do hereby hold the District and its employees harmless from any and all claims, demands, causes of action, liability or loss of any sort of or arising out of acts or omissions of the District or its employees with respect to this medication.

Name of Student: _____ Date of Birth:_____

Name of Medication:_____ Exp. Date_____

Reason for Medication:_____

Dosage :_____ Quantity of medication received:_____
(how much, how often, etc)

Start Date:_____ Stop Date:_____

Parent/Guardian Signature: _____Date: _____

Home Phone: _____ Cell Phone: _____

Emergency Phone: _____

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Staff Signature: _____ Date Received: _____

Picked up by (name): _____ OR Disposed of on (date):_____