Authorization for
Over-The-Counter Medication
Parkway Local Schools

To the parent:

The following approval is **necessary** for any student to use non-prescribed medications in schools. The school will not be responsible to supply over-the-counter medications. All spaces must be completed. **Students MUST have their own bottle of medication at the school. Parents/guardians must bring medications to school. Medications are not permitted on school busses according to the Ohio Revised Code.**

Student Name: _____ School: Parkway Local Schools

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

   Medication: _____ Dosage: _____
   Medication: _____ Dosage: _____
   Medication: _____ Dosage: _____
   Medication: _____ Dosage: _____
   Medication: _____ Dosage: _____

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(s) 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.

Signature of Parent: _____ Date: _____

Home Telephone: _____ Work/Cell: _____