

TRAVERSE CITY CHRISTIAN SCHOOLS

753 Emerson Rd., Traverse City, MI 49696 ~ 929-1747

Over-the Counter Medication Authorization Form

Parent must complete and sign if over the counter medication is to be kept/administered at school

Student Name _____ /_____/_____
(last) (first) birthdate

Child's Grade _____

Name of Medication _____

Amount/frequency to be given _____

Instructions on administering medication _____

I request and give permission for (child's name) _____ to receive the above medication at school according to school standards. I, as parent/guardian acknowledge that *I am required to bring medication labeled correctly in its original container* and it is my responsibility to supply/renew the medication for my child.

I the parent/guardian understand that it is my responsibility to immediately notify the administration of any discontinuance or modification in my child's medication.

I release the school administrator, office staff, all teachers and other school employees designated by the school administrator who in good faith administer medication to my child as instructed above or in an emergency that threatens the life or health of my child, pursuant to my written permission, from criminal liability and civil damages as a result of an act or omission in the administration of the medication, except for an act or omission amounting to gross negligence or willful or wanton misconduct.

Parent/Guardian Signature

Date