Kim Pittser, Superintendent
Cari Wilson, Treasurer/CFO

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Miami Trace
Local School District
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AUTHORIZATION FOR NON-PRESCRIBED MEDICATION OR TREATMENT

*A separate medication form is required for each prescription and non-prescription medication administered.

Name:_____DOB:_____

Student address: _____

School: _____ Grade: _____

Medication Name:_____ Dose:_____ Route:_____

Dosage Time/s:_____ Reason for Medication:_____

Start date: _____ Stop date: _____

Special Instructions: _____

_____

A. **THIS MEDICATION MUST BE BROUGHT TO SCHOOL IN THE ORIGINAL, *UNOPENED* BOTTLE PROVIDED FROM HOME. THE SCHOOL WILL NOT BE PROVIDING MEDICATION.**
B. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
C. 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 Telephone