Springboro Community City Schools
1685 South Main Street
Springboro, OH 45066
(937) 748-3960

REQUEST TO ADMINISTER Over-The-Counter(OTC) MEDICINES

Please Complete and Return to Building Nurse.
THIS FORM IS VALID FOR CURRENT SCHOOL YEAR ONLY.

Name		**DOB**	
Address		**Telephone#**	
School		**Grade/ Teacher**	

To be Completed By the Parent/Guardian:

Start Date		**End Date**	

Name of Medication:	
Dosage:	
Time to be Administered:	
Special Storage Instructions:	

I, hereby, authorize designated school personnel of the Springboro Community City Schools to administer the above medication and agree to:
1. Provide the school with the medication in the original bottle/box with all drug related information and expiration date visible.
2. Notify the school if the medication, dosage, or procedures is changed or is to be eliminated.
3. Release authorized school personnel from all liability, cause of action, or any other responsibility for administering said medicines as noted above.
4. The Board Substance Abuse Policy and the Student Code of Conduct Policy would apply to any student dispensing, selling, and/or having possession of medication at school.

Parent Signature	**Telephone Number**

To be Completed by School Personnel:

I, hereby, acknowledge reading this request to administer medication; and understand its content, as well as the content of the Board of Education policy.

C**linic Nurse Signature**	**Date**