Traverse City
CHRISTIAN SCHOOL

753 Emerson Rd., Traverse City, MI 49696 231-929-1747

Over the Counter Medication Authorization Form (2024-25 SY)

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

Student Names	Birthdates	Grades
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____
_____	___/___/___	_____

Name of Medication(s):

Please indicate which student it's for by using initials (ex: MB - Ibuprofen) or write "All" if all your students can take the med.

_____

_____

_____

Amount/frequency to be given- Choose one: ___As directed ___As needed ___or see below:
Directions_____

_____

_____

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

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

I release the school administrator, office staff, all teachers and other school employees designated by the school administrator who in good faith administer medication(s) 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(s), except for an act or omission amounting to gross negligence or willful or wanton misconduct.

_____
Parent Name (Printed)

_____ _____/_____/_____
Parent/Guardian Signature Date