Portland Christian School System

Authorization/Parental Consent for Administering Over-the-Counter Medication

Student's Last Name ____________________________ First Name _____________________ MI _____

Student SS # ________________________________ Grade ________ DOB _____/_____/_____

Allergies ____

Parental Consent

I am the parent/guardian of ______________________________________. I give my permission for him/her to take the following over-the-counter medication (see below) at school. I hereby acknowledge that I have read and understand Portland Christian Schools requirements for distribution of medication to students. I hereby release Portland Christian School and its employees from any claims or liabilities connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

X_________________________________ __________________________ ________________
Parent/Guardian Signature **Daytime Phone** **Date**

Over the counter medications can be given no more than 3 consecutive days without a physicians order.