

**AUTHORIZATION FOR ADMINISTRATION OF OVER THE COUNTER
MEDICATION AND RELEASE OF LIABILITY**

The undersigned hereby designate trained personnel:
School Nurse, Principal, Secretary or Teacher (Field Trip only)

And hereby authorize these personnel of Sheridan County School District No. 2, State of Wyoming, to administer the following medication to:

NAME OF CHILD: _____ DATE OF BIRTH: _____

SCHOOL: _____ GRADE: _____

NAME OF MEDICATION (Check/mark those authorized to be administered to the above student):

- Acetaminophen (generic Tylenol)
- Ibuprofen (generic Motrin/Advil)
- Antacid tablets (generic Tums)
- Diphenhydramine (generic Benadryl)
- Other over the counter medication:

(provided by parent/guardian in original container with any necessary instructions and purpose to be administered)

INSTRUCTION FOR ADMINISTRATION: Given according to the manufacturer's directions on the original container and/or standardized dosing charts for pediatric age children.

In consideration of District personnel administering such medicine, the undersigned hereby releases, indemnifies, and holds harmless Sheridan County School District #2 and its personnel from all claims, demands and liabilities, direct and indirect, which may result or accrue by reason of the administration of such medicine, the failure to administer it, or the improper administration thereof.

I have read and understand this authorization. I hereby give my permission for _____ to take the above over the counter medication at school.

_____ Date _____ Parent or Legal Guardian

First Reading: 3-1-21
Second Reading: 4-5-21