AUTHORIZATION FOR MEDICATION ADMINISTRATION

I, _____, the Parent/Legal Guardian of _____,
(first & last name of Impact student)

authorize Impact Academy to make available the following non-prescription medication(s): of Tylenol ☐ Ibuprofen ☐ Aspirin ☐ when student is complaining of, or experiencing, headaches, body aches, and/or swelling for student self-administration.

I also authorize Impact Academy to make available the following prescription medication(s):

_____ of _____ at _____
(dosage amount[s]) (prescribed medication[s]) (time[s] of day)

as prescribed by _____ for student self-administration.
(prescribing doctor's name)

I acknowledge my responsibility in letting Impact Academy know if my child's prescribed medication(s) or doctor(s) are changed or removed. In addition, I pledge to adhere to all guidelines in accordance with the Ohio Revised Code and Impact Academy.

I do not and will not hold Impact Academy or any of its employees responsible for any and all relevant liabilities that may emerge, directly or indirectly, during the course, or as a result, of the self-administration of the above-listed prescribed medication(s) to my child.

Parent/Legal Guardian Signature _____ Date _____

Student/Patient Residing Address _____
(Street, City & ZIP Code)

Phone (_____)_____ Other Phone (_____)_____ D.O.B. _____

Potential Side Effects, Reactions, Contraindications, or Special Instructions _____

_____

_____