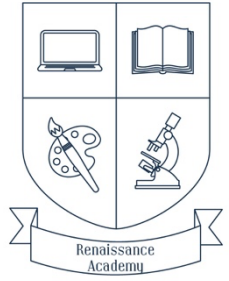


Parent/Guardian Authorization for Non-Prescribed Medication or Treatment

The following information is required for any student to use non-prescribed medications at Renaissance Academy. All spaces must be completed.

One form per type of medication. Click here for additional forms. Will you have additional forms?



Student Last Name _____ **Student First Name** _____

Grade _____

I am requesting permission for my child named above to use or receive the following over-the-counter medication(s) or FDA approved topical substance:

Medication/ Topical Substance _____ **Dosage**

To be taken in the following circumstances:

I give my student permission to self-carry and self-administer administer above listed medication(s) with the knowledge of and in the presence of a Renaissance staff member. All self-carry medication will be in its original container and labeled with the student's name.

I will assume responsibility for the safe delivery of the medication to Renaissance Academy labeled with my student's name and in its original container. I will notify Linda Percy (lindapercy.ra@gmail.com) immediately if there is any change in the use of the medication or the prescribed treatment.

I release and agree to hold the Renaissance Academy, its staff, employees, and volunteers harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Name of Parent/Guardian _____ Date _____

Signature of Parent/Guardian _____

Mobile Phone _____ Alternate phone _____

Linda Percy, Renaissance School Nurse Acknowledgement of Receipt of Medication
and Review of Non-Prescription Medication Authorization

Date _____