Throat Lozenges/Cough Drops – Temporary relief of cough, pain associated with sore throat, sore mouth. Dosing per label.

Other as Listed by Physician - _____

For all parents/guardians:

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to *self-administer* pursuant to State law, while under the supervision of the employees and agents of the School District), the above medications per the above protocols. **I have drawn a line through any medications that I DO NOT wish to be given to my child.** This consent will be renewed annually and may be modified/withdrawn at any time.

I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

_____

Parent/Guardian Printed Name

Address (if different from Student's above): _____

Home Phone: _____ Cell Phone: _____ Emergency Phone: _____

_____ _____

Parent/Guardian Signature Date

To be completed by the student's physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority:

Physician's Printed Name: _____

Office Address: _____

Emergency Phone:

Office Phone: _____ _____

_____ _____

Physician's Signature Date