PARENT AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION
OR
SHORT TERM PRESCRIPTION MEDICATION (taken less than 14 days)

Student's Name_______________________________________ ID#_______________________________

Date of Birth____________ School____________________________ School Year________________

Name of medication_________________________________ Dosage__________________________

Time of administration____

Special instructions/reason for medication: ____

Will the student be carrying and taking this medication on his/her own? ☐Yes ☐No

Students are not allowed to carry controlled substances (for example, Tylenol #3) and will be required to come to the Health Office to take any medication classed as a controlled substance.

If YES is selected: I/We understand that our child will be responsible for carrying and taking his/her own medication and that he/she is only authorized to carry one day's supply of medication in the ORIGINAL LABELED container indicating the name of the medication and the dose of the medication or dosing recommendations.

A student requiring OTC medication more than 3 times/month or more than 3 consecutive days should be considered for a medical evaluation.

Parent/Guardian Signature: ____________________________________Date: ______________________

Phone #(s): _________________________________ ____

School Nurse Signature: ____ Date: _____________________

Date ______________ medication brought for storage in the Health Office. **Expiration date**: __________
Amount of medication _______________________________ (two adults count medication and record)

____ ______________________________________
Signature of person counting Signature of person counting

End of Year Instruction:
☐ I will pick up unused medication on the last day of school (medication will be discarded if I do not pick it up by the end of the day)
☐ Please discard unused medication on the last day of school
Date: ____________medication ☐ returned ☐destroyed at end of school year.

____ ______________________________________
Signature of person returning/discarding med Signature of person picking up/discarding med

OTC/SHORT TERM PRESCRIPTION INDIVIDUAL MEDICATION LOG

Student's Name_______________________________________ ID#______________________

Date of Birth____________ School____________________________ School Year__________

Name of medication: _________________________________ Dosage: ______________________

Time of administration/instructions: ____

____ Nurse signature and initials

____ Nurse signature and initials

____ Health assistant and initials

____ Staff signature and initials

____ Staff signature and initials

____ Staff signature and initials

DATE	TIME	INITIALS	PARENT NOTIFIED	DATE	TIME	INITIALS	PARENT NOTIFIED