



**PARENT AUTHORIZATION FOR
OVER-THE-COUNTER MEDICATIONS**

(Please complete every item on this form)

Student's Name _____ Student No. _____
Date of Birth _____ School _____
Name of medication _____ Dosage _____
Time of administration _____
This student is expected to be receiving this medication for _____
(How long?)
Special instructions regarding this medication _____

Will this 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 Room to take any medication classed as a controlled substance.

If NO is selected. I/We understand that our child _____ will be assisted to self administer the over-the-counter medication by designated school personnel and the parent will be notified each time the dose is taken by the child and of the circumstances regarding the dose being taken.

If YES is selected. I/We understand that our child _____ will be responsible for carrying and taking his/her own medication (if we have selected this option), and that he/she is only authorized to carry one day's worth of medication in the ORIGINAL LABELED container that indicates the name of the medication, and the dose of the medication or dosing recommendations.

I/We understand that if our child _____ needs to take a non-prescription over-the counter medication for more than 5 consecutive school days we will be asked to get a written physician/provider authorization before any more of the medication will be given.

Parent/Guardian Signature _____
Printed Name _____
Date _____ Phone no(s) _____
Home Mobile

Medication brought by student for storage in the Health Room _____
Date _____

Amount of medication _____ (two adults count pills and record amount)

Signature of person counting

Signature of person counting