AUTHORIZATION FOR OVER THE COUNTER MEDICATION AT SCHOOL

(MUST BE SIGNED BY PARENT)

PLEASE PRINT SCHOOL YEAR: _____

STUDENT'S NAME: _____ BIRTH DATE: _____

LEGAL GUARDIAN: _____ DAYTIME PHONE: _____

NAME OF MEDICATION:

_____

REASON FOR GIVING MEDICATION AT SCHOOL (PLEASE BE SPECIFIC):

_____

AMOUNT OF MEDICATION TO BE GIVEN: _____

TIME OF DAY MEDICATION IS TO BE GIVEN AT SCHOOL: _____

DATE TO START MEDICATION: _____ DATE TO STOP MEDICATION: _____

EXPIRATION DATE OF MEDICATION: _____ POSSIBLE SIDE EFFECTS:_____

_____

PHYSICIAN: _____

PHYSICIAN'S PHONE #: _____

PARENTS PLEASE READ CAREFULLY: I understand that all medication will be provided by me in the original container, clearly labeled with my child's name. I will notify the school if the medication is discontinued or the dosage has been changed. Permission is granted to the principal and/or school nurse to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I give the school nurse my permission to contact the above named physician's office to request medical information concerning my child. I am responsible for replacing medication before the expiration date.

LEGAL GUARDIAN'S SIGNATURE: _____ DATE: _____