



## **AUTHORIZATION TO ADMINISTER NONPRESCRIPTION MEDICATION**

Complete *one form for each medication*. Guidelines on Reverse Side ⇨

### PLEASE PRINT

School Year: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_ Room: \_\_\_\_\_ Teacher: \_\_\_\_\_

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

I, the parent or legal guardian of the above named student, have read and understand the Medication Guidelines on the reverse side. I understand that medications are NOT given by licensed medical professionals but by designated trained school personnel. I give my permission for designated school personnel to administer to my child the nonprescription (over the counter or OTC) medication listed below according to my written instructions. I further give permission for designated school personnel to request and share relevant health information about my child and the administration of this medication with appropriate school personnel.

**I agree to:**

- Deliver or assume responsibility for safe delivery of the medication to school.
- Provide the medication in the original, labeled, unopened manufacturer's container with my child's name clearly written on it.
- Submit a new written authorization form if any change in taking this medication occurs.
- Notify the school in writing immediately if there is a discontinuation of this medication.
- Pick up any unused medication

Medication: _____	Strength: _____
Taken for: _____	Amount to be given: _____
Time(s) to be given: _____	
How often to be given: _____	
If given <b>as needed</b> state specific symptoms or conditions for which it is to be given: _____	
_____	

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_