OVER THE COUNTER – MEDICATION AUTHORIZATION FORM

Medication must be sent to school in original container in order to be dispensed by school personnel.

Name of Student _____ Date of request_____

Address_____ Homeroom or teacher_____

_____ Grade_____

Any known allergies_____

Name of medication_____

Purpose of medication_____
(May be given for (i.e. cramps, headache, pain, etc.)

Dosage (how much/many)_____

Times/Intervals medication is required_____

_____

Possible reactions which should be reported to you_____

_____

Special instructions, including storage_____

_____

Date medication to begin_____

Date medication no longer needed_____

PARENT/GUARDIAN AUTHORIZATION

I, _____ (name of parent/guardian) authorize the school personnel to administer the medication as instructed by me, and agree (1) to deliver the medication to the school, and (2) to notify the school if there is a change in the medication, dosage or time interval, and (3) to notify the school if the medication is to be discontinued.

_____ _____
(Signature of parent/guardian) (Date)

Phone numbers: Home:_____ Work:_____ Cell:_____

***NOTE: AUTHORIZATION FORM MUST BE COMPLETED EACH SCHOOL YEAR. PLEASE RETURN THIS FORM BEFORE SCHOOL BEGINS OR BY THE FIRST DAY OF SCHOOL.**