PARENT AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION

AND

PRESCRIPTION MEDICATION

Student Name: Date of Birth:Click or tap to enter a date.

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 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 student 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: Click or tap to enter a date.

Phone #(s):

School Administrator Signature: Date: Click or tap to enter a date.

Date: Click or tap to enter a date. medication brought for storage in the Health Office.

Expiration date: Click or tap to enter a 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: Click or tap to enter a date. Medication ☐ returned ☐destroyed at end of school year.

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