



Authorization to Administer Over-the-counter (non-prescription) Medication

Student _____ Birthdate _____

School _____ Grade _____ School Year _____

Parent/Guardian 1: _____ Parent/Guardian 2: _____

Daytime Phone (_____) _____ Daytime Phone (_____) _____

Cell (_____) _____ Cell (_____) _____

Authorization expires at the end of the school year or following the summer school session.

Parent/Guardian Consent:

I give permission for my son/daughter to receive the medication listed below. I also give permission for an exchange of information between school district personnel and the health care provider, if necessary, regarding this medication. I agree to notify the school in writing at the withdrawal of this request or when a change in this medication occurs.

I understand that it is my responsibility to:

- Transport the medication to school in the original container/packaging or a *pharmacy-labeled* container (4K-8th grade)
- Replace the supply of medication when needed
- Pick up medication or direct staff to discard remaining medication upon discontinuation or at the end of the school year

Parent/Guardian Signature _____ Date _____

- **NOTE:** An Authorization to Administer Prescribed Medication form is required if:
 - *the medication contains a narcotic (usually prescribed for pain)* **OR**
 - *the medication dosage exceeds the manufacturer's recommendation* **OR**
 - *a short-term prescription medication is needed for more than 2 weeks*

Reason:		
Name of Medication: (generic and trade)		
Dosage of Medication:	_____ mg / cc / tsp _____ drops / puffs	Form: <input type="checkbox"/> Tablet / Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Ointment / Cream <input type="checkbox"/> Inhaled <input type="checkbox"/> Eye / Ear / Nose Drops
Route:	<input type="checkbox"/> Oral <input type="checkbox"/> Eyes <input type="checkbox"/> Ear <input type="checkbox"/> Nose <input type="checkbox"/> Topical	
Time to be given:	<input type="checkbox"/> As needed - Describe frequency & symptoms for which medication should be given: _____ <input type="checkbox"/> May be repeated in _____ minutes/hours. <div style="text-align: center; font-size: small;">(time)</div>	

FOR SCHOOL USE

• Date received: _____

• Name of person(s) who will administer the Medication:

• Approved by: _____ (Principal's Signature) _____ (Date)

• _____ Referred for administrative review. Send to School District Nurse with concerns about this authorization.