



## Over-the-Counter Medication Authorization Form

*to be completed by Parent or Guardian if needing OTC medication regularly*

Permission is hereby granted to the designated employees of Porter-Gaud School to supervise my child in taking the following over-the-counter medication.

Name of student: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Grade in 2020-2021: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Route of administration: \_\_\_\_\_

Time(s) to be administered: \_\_\_\_\_

Possible side effects of medication: \_\_\_\_\_

Expected duration of need: \_\_\_\_\_

Other medications the student is taking concurrently: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

Comments / Specific instructions: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Cell phone #

Please return to: Porter-Gaud School

Email: [nurse@portergaud.edu](mailto:nurse@portergaud.edu)