Over The Counter Medication Form

Northmont City Schools
4001 Old Salem Road
Englewood OH 45322

Additional OTC Medication

Provided by Parent/Guardian

Name of Student: _____ Student's birthdate: _____

School Building: _____ Grade:: _____ Team/Teacher:_____

My child may take the medication listed below. I understand that non-medical school personnel may administer this medication. This authorization will be in effect for the current school year unless revoked in writing by the parent/guardian.

As parent/guardian, I have supplied the following over the counter medication for my child to take as needed. I understand that the school district maintains the right to restrict the use of this form for certain over the counter medications. Directions will be followed as directed on the original packaging/bottle to determine dosage.

Frequent use MAY require a doctor's order-per nurse discretion

Name of medication: _____

****Directions will be followed as directed on the original packaging/bottle to determine dose and frequency****

_____ _____
Parent/Guardian signature Date

_____ _____ _____
Cell Phone Daytime Phone Evening Phone

FOR SCHOOL USE: Document in pen: **date, time and initial** when a medication is given. If it wasn't documented, it wasn't done.

Date	Medication	Dose	Time	Reason	Initials

School Employee Signature: _____