Over-the-Counter Medication Authorization

Students in grades 6-12 may be administered school provided non-prescription, over-the-counter medications while at school provided the following guidelines are met:

- Parent or guardian's written authorization is present.
- Dose administered will not exceed the recommended dosage on the labeled container.
- Your student must not be allergic to any ingredients of the medication listed below.
- Parent or guardian must provide medication if "OTHER" is checked and filled out. *This includes Children's Liquid/Chewable Pain Relief medications.*
- Parent or guardian may be asked to provide student's own bottle of medication if needing the medication frequently.
- Authorization must be renewed yearly.

By checking and authorizing administration of over-the-counter medications to my son/daughter during school hours, I release school personnel from any liability in relation to this request when medication is given as directed. I will notify the school health office of any change in the medication (dose change, discontinuation of medication, etc.). I give permission for the school health service office to communicate with school staff about the action and side effects of medications on a need to know basis. I also give permission to the assigned teacher/responsible adult to administer the medications on a field trip following school protocol.
Please note that some medications may be generic. Please contact the Health Office if you have any questions or concerns.

Student Name:_____ **Date of Birth:** _____
Last **First**

Print Parent/Guardian(s) Name: _____**Date:** _____
(Please Print) **Last** **First**

Signature authorizing administration of medication: _____

PLEASE LIST ALL MEDICATION ALLERGIES_____

CHECK THE BOX NEXT TO EACH MEDICATION YOU WOULD LIKE TO AUTHORIZE FOR YOUR STUDENT

☐ **Ibuprofen** 200mg (*Headache, Cramping, General Pain/Aches*)

☐ **Acetaminophen** 500mg (*Headache, Cramping, General Pain/Aches*)

☐ **TUMS** 750mg (*Heartburn, Acid Indigestion*)

☐ **Benadryl** 25mg (*Seasonal Allergies, Insect Bites, Hives, etc.*)
☐ **Other** (Turn page)

☐ **OTHER:**_____ *Reason:*_____
Must provide own bottle *Dose:*_____
*Frequency:*_____

☐ **OTHER:**_____ *Reason:*_____
Must provide own bottle *Dose:*_____
*Frequency:*_____

☐ **OTHER:**_____ *Reason*:_____
Must provide own bottle *Dose*:_____
Frequency:_____