Authorization for the Administration of Over-the-Counter / Non-Prescription Medication/Treatment

Student: _____ **DOB:** _____ *(circle)* **Male / Female**
School: _____ **Grade:** _____
Parent/Guardian Name: _____ **Phone**:_____
Address: _____

Parents/guardians asking school staff to give medications to their child must provide (written permission every school year that has been signed by the parent/guardian. Under certain circumstances, as identified by the Licensed School Nurse, a written authorization form may need to be completed and signed by the student's Healthcare Practitioner. Over-the-counter medications must be in the original container with dosing recommendations visible.

To be completed by the Parent/Guardian in collaboration with with Licensed School Nurse

Medication / Treatment: _____

Reason for Use: _____

Dosage: _____ **Route:** _____ **Frequency:** _____

Additional Instruction: _____

Start Date: _____ **Stop Date:** _____
(All authorizations expire at the end of the school year or following the end of summer school programming.)

*_____ _____
Signature of Parent/Guardian **Date**

Return to : Brooklyn Center School -District 286
Deb Erickson, Licensed School Nurse
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