

**PARENT AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION
OR
SHORT TERM PRESCRIPTION MEDICATION (taken less than 14 days)**

Student Name: _____ ID#: _____

Date of Birth: _____ School: _____ School Year: _____

Name of medication: _____ Dosage: _____

Time of administration: _____

Special instructions/reason for medication: _____

Will the student be carrying and taking this medication on his/her own? Yes No

Students are not allowed to carry controlled substances (for example, Tylenol #3) and will be required to come to the Health Office to take any medication classed as a controlled substance.

If YES is selected: I/We understand that our child will be responsible for carrying and taking his/her own medication and that he/she is only authorized to carry one day's supply of medication in the ORIGINAL LABELED container indicating the name of the medication and the dose of the medication or dosing recommendations.

A student requiring OTC medication more than 3 times/month or more than 3 consecutive days should be considered for a medical evaluation.

Parent/Guardian Signature: _____ Date: _____

Phone #(s): _____

School Nurse Signature: _____ Date: _____

Date _____ medication brought for storage in the Health Office. Expiration date: _____	
Amount of medication _____ (two adults count medication and record)	
_____ Signature of person counting	_____ Signature of person counting

End of Year Instruction:	
<input type="checkbox"/> I will pick up unused medication on the last day of school (medication will be discarded if I do not pick it up by the end of the day)	
<input type="checkbox"/> Please discard unused medication on the last day of school	
Date: _____ medication <input type="checkbox"/> returned <input type="checkbox"/> destroyed at end of school year.	
_____ Signature of person returning/discarding med	_____ Signature of person picking up/discarding med