Mounds View PUBLIC SCHOOLS

PARENT AUTHORIZATION FOR USE OF OVER-THE-COUNTER MEDICATION

Student Name:_____ Grade:_____ Date:_____

Name of Medication: _____ Dose: _____

Reason Taken: _____

When Medication should be taken: _____

How: _____ with food _____with water _____ on an empty stomach

_____ other _____

_____

Common side effects: _____

Note when health care provider should be contacted:

_____ if medication is no longer helpful

_____ if there are serious side effects

_____ other _____

Known allergies: _____

Parent Signature Date

Name of Health Care Provider Phone