

**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. <b>Expiration date:</b> _____	
Amount of medication _____ (two adults count medication and record)	
_____	_____
Signature of person counting	Signature of person counting

<b>End of Year Instruction:</b>	
<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

**OTC/SHORT TERM PRESCRIPTION INDIVIDUAL MEDICATION LOG**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ ID#: \_\_\_\_\_

Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time of administration/instructions: \_\_\_\_\_

\_\_\_\_\_  
Nurse signature and initials

\_\_\_\_\_  
Nurse signature and initials

\_\_\_\_\_  
Health assistant signature and initials

\_\_\_\_\_  
Staff signature and initials

\_\_\_\_\_  
Staff signature and initials

\_\_\_\_\_  
Staff signature and initials

**ADMINISTRATION LOG**

DATE	TIME	INITIALS	PARENT NOTIFIED	DATE	TIME	INITIALS	PARENT NOTIFIED