



PARENTS AUTHORIZATION TO ADMINISTER NON-PRESCRIPTION MEDICATION

I do hereby authorize the school principal, teacher or other school employee designated by the principal to administer the non-prescription medication described below to my child, _____ ,
in the dosage and at the frequency indicated below.

Name of Medication: _____

Dosage: _____

Frequency: _____

I further understand that I will be responsible for supplying this medication to the school in the original labeled container as purchased over the counter to properly identify same.

Date

Parent / Guardian Signature

Telephone

Address

PLEASE NOTE: The Physician's Statement and the Parent's Authorization are valid only for the current school year.

Unless the authorization and statement are renewed, the medication cannot be given to the student.

TO BE PLACED IN LOCKED STORAGE AREA TOGETHER
WITH THE NONPRESCRIPTION MEDICATION