AUTHORIZATION FOR ADMINISTRATION OF OTC MEDICINE BY SCHOOL PERSONNEL

CASTON SCHOOL CORPORATION
PHONE 574-598-8000
FAX 574-598-8002
Nurse Ext. 335

Parents of students requesting OTC medication be administered during school hours by school staff are required to:

1) **COMPLETE** this form and return
2) Supply medication in **ORIGINAL CONTAINER**
3) Frequency/Dose must be **ACCORDING TO MANUFACTURER'S DIRECTIONS**
4) Substances that are **not FDA approved**, will not be given.

Student _____ Date of Birth _____ Grade/H.Room_____

Medication _____

Dose_____ Time of Administration_____

If as needed, frequency_____Allergies ( ) No ( ) Yes, Specify _____

I request the above medication be administered by school personnel. I understand this medication will be destroyed if not picked up on the last day of school. To promote safety for your child, medication information may be shared with school personnel working with your child and with emergency personnel, if they are called.

PRINT PARENT NAME _____ DATE _____

PARENT SIGNATURE _____ DATE _____

HOME PHONE _____ CELL/WORK _____