NON-PRESCRIPTION MEDICATION AUTHORIZATION
FAIRLESS LOCAL SCHOOLS 2026-2027

Dear Parents and Guardians,

Fairless Local Schools does not provide over-the-counter medications (Tylenol/Advil etc.) for student use. As per policy, in order for your student to take over-the-counter medications at school, the following procedure must be followed:

Please complete and sign the attached Over-Non-Prescription Medication Authorization Form and return to the school. The medication must be *brought to the school by the parent or designated responsible adult*.

- All medications must be in the original container with the student's name marked on the bottle/package.
- Medications will be stored in the locked medication cabinet in the clinic. Students are not permitted to keep any medication with them or in their lockers, with the exception for asthma inhalers, auto-injector epinephrine, or diabetic supplies provided the appropriate forms have been completed by the physician and parent.
- Students must take their medication in the clinic.
- If there is any change in the medication, dose, or instructions, a new parent permission form must be completed.
- A new medication form is required EVERY school year.

As the staff caring for the students, we are very concerned about the health and safety of all students in our schools. This medication policy and procedure ensures the safe administration of medication to your student and promotes a safe school building. If you have any questions or concerns, please contact us at your child's school.

Respectfully,
Fairless Local Schools Staff

Please keep this page for reference.

NON-PRESCRIPTION MEDICATION AUTHORIZATION
FAIRLESS LOCAL SCHOOLS 2026-2027

The following information is necessary for any student to receive any over-the-counter medication while in school. All spaces must be completed. One medication per form only. NOTE: ALL NON-PRESCRIPTION MEDICATIONS MUST BE ADMINISTERED ACCORDING TO PACKAGE/DOSAGE DIRECTIONS UNLESS OTHERWISE ORDERED BY A PHYSICIAN.

Student Information:

Student Name:		**DOB**	
Student Address:			
School:	**Grade:**	**Teacher:**	
Known Allergies:		**Height:**	**Weight:**
Name of Medication:		**Reason for Use:**	
Dosage:	**Route:**	**Time/Interval:**	
Date to Begin:		**Date to End:**	
Possible Side Effects:			

I understand that I (parent/guardian) am responsible for the safe delivery of all medications to the clinic.

I agree:

1. To store all medications in the clinic in the original container.
2. To instruct my child to take the medication in the clinic.
3. To submit a new form if the medication, dosage, or instructions have changed.

I Hereby release the Fairless Local Schools, Board of Education, its officials and staff from any and all liability for damages or injury or indirectly resulting from my child's use of the over-the-counter-medication.

Parent/Guardian Signature:	**Date:**
Phone Number:	**Additional phone:**

NON-PRESCRIPTION MEDICATION AUTHORIZATION
FAIRLESS LOCAL SCHOOLS 2026-2027

THIS PAGE FOR OFFICE USE ONLY				
Dae	Time	Dose	Complaint/Comment	Initials

Initials Signature

_____ _____

_____ _____

_____ _____

_____ _____