Elder Grove School
Authorization for Occasional/Frequent Over the Counter Medication/Treatments

Name of Student: _____Date of Birth : _____ Grade _____

Medication Allergies: _____

Over the Counter Medications
By initialing below, I give permission for school nurse/school personnel to administer the following medication (s) as needed to my student for minor discomfort or injury.

_____	Acetaminophen (i.e. Tylenol, Midol)	Dosage _____
_____	Ibuprofen (i.e. Advil, Motrin)	Dosage _____
_____	Antihistamine oral (i.e.Benadryl/Zyrtec)	Dosage _____
_____	Antacid (i.e. Tums, Pepto)	Dosage _____
_____	Age appropriate Cough/Cold Medication	Dosage _____

Parents may also supply other over the counter medications, please list below:
Medication name: _____ Dosage: _____
Reason given: _____ Time: _____
Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

For frequent or daily use of over the counter medications:

- I will bring the medication to the school myself or by another responsible adult.
    - Students are not allowed to carry medication unless allowed to do so by law or specific school plan.
    - Students will not be given narcotic medications unless allowed by a specific school plan.
- I understand that over the counter medications must be brought to school in the original container with a label intact.
- I understand that I will also need to complete a medication drop off and pick up form regarding the above medication for drop off and pick up procedures. Medication must be picked up at the end of the school year or it will be disposed of.

Duration of Order: ***Valid until the end of middle school unless otherwise noted.***
Other length of duration: _____

_____ _____ _____
Parent/Guardian Printed Name Parent/Guardian Signature Phone #

****

School Nurse Signature: _____ Date Order Reviewed:_____