OVER THE COUNTER MEDICATION AUTHORIZATION FORM

_____ _____
Name of Student Grade

Student Allergies: _____

The Willow River School District Health Office Staff has my permission to administer the following in the dosage and time frame recommended on the medication package to my child.

_____ (Must use one form per medication)
Medication Name

For the following symptoms: _____

I understand and agree to the following:

1. **All medication must be provided in the original container**. Medication sent to school in a plastic baggy, envelope or other containers will not be administered and will be returned with the student.

2. A written statement will be submitted to the school nurse when the medication is to be discontinued.

3. **All medications given by school staff must be approved by the FDA**.

4. **All medication must state it is approved for use in children**. If a medication is not approved for use in children, it will require a Physician/Licensed Presriber's order for administration. Please ask your Physician/Licensed Provider to provide the school with written orders to administer this medication to your child.

5. This permission is no longer valid at the end of the school year. The medication will be disposed of at this time if arrangements are not made by the parent to pick up the remaining medication.

_____ _____
Parent/Guardian Signature Date

At the end of the school year, Medication supply to be sent home-please initial below:
_____Send with Student

_____Parent/Guardian to pick up

Other: _____

For Office Use only: Medication must be in the original container, approved for use in children, FDA approved, and parent permission. Administer per label recommended directions only.

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