OVER THE COUNTER MEDICATION AUTHORIZATION FORM

This form is only good for ONE school year
2023-2024 School Year

This form must be signed by your PHYSICIAN for all OVER THE COUNTER medications to be given at school.

Student's Name: _____ **D.O.B.:** _____

Teacher: _____ **Grade:** _____

Home Phone: _____ **Emergency Phone:** _____

Name of Medication: _____

Dosage: _____ Frequency: _____

Time medication is to be administered at school or under what circumstances: _____

_____

Order Date: _____ Discontinue Date: _____

Physician's Name (Please Print): _____

Physician's Address: _____

Physician's Phone: _____ Physician's Fax: _____

Physician's Signature: _____ *Date:* _____

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by the School District and its employees and agents. I understand that I must provide all medication in the original bottle, with the student's first and last name written on the bottle. I understand that medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first. I also understand that my signature allows for verbal communication as necessary between the school nurse and the above prescriber to ensure safe administration of all medication marked above.

Parent/Guardian Printed Name: _____

Signature: _____ *Date:* _____

Policy 7:270
Adopted and Revised: June 2023