PARENT AUTHORIZATION TO ADMINISTER OVER THE COUNTER MEDICATION

Over the counter, also known as non-prescribed medication, means medication and food supplements that have been approved by the FDA and may be obtained over the counter without a prescription from a licensed prescriber.

In order to keep this student in optimum health and to help maintain maximum school performance, it is necessary that the following medication be taken during the school day and school related activities:

The parent/guardian must complete all of the information.

Student's Name _____ Date_____
Teacher_____Grade_____Date of Birth_____
Allergies _____ This authorization is valid until _____

School_____ School Year _____

Name of medication:_____

How often to take or time of day to take:_____

Dosage: _____
(Please list the mg. dosage of each tablet and how many tablets to take each time)

Route of administration: _____By mouth _____Apply to skin _____Other (specify_____)

This medicine is intended for the following purpose:_____
(An example would be—To relieve headache, toothache To relieve runny nose To relieve cough)

Other medication taken by the student include:_____

If the student is in grades 9 through 12, they may be allowed to carry the above medication with them. No more than 3 doses may be carried in the labeled container if the student carries the medication with them.
_____ I do not want my child to carry this medication on their person.

Parent/Guardian signature_____ **Date** _____

The over the counter medication must be in the originally labeled container with the following information attached to the container (you may cut these labels, fill in the information and tape to the original container).

Name_____ **Date**_____	**Name**_____ **Date**_____
Name of medicine_____	**Name of medicine**_____
Reason for the medicine_____	**Reason for the medicine**_____
Dosage _____	**Dosage** _____
Time or how often to take_____	**Time or how often to take**_____
Circle one By mouth Apply to skin Other	**Circle one By mouth Apply to skin Other**
Date the medication expires_____	**Date the medication expires**_____