

Authorization for Administration of OTC Medication at School

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: _____ D.O.B. _____

School: _____ Grade: Level _____

<u>NAME OF MEDICATION</u>	<u>DOSAGE</u>	<u>ROUTE</u>	<u>REASON TO BE GIVEN</u>
#1 _____	_____	_____	_____
#2 _____	_____	_____	_____
#3 _____	_____	_____	_____
#4 _____	_____	_____	_____

PLEASE NOTE: OVER-THE-COUNTER MEDICATIONS WILL BE GIVEN ONLY FOR REASONS STATED, SO PLEASE LIST ALL REASONS TO GIVE MEDICATION.

Medications **will not be given** in larger doses more often than directed by manufacturer without a doctor's note.

Possible side effects of medication:

- #1 _____
- #2 _____
- #3 _____
- #4 _____

**Parent/guardian/caretaker will provide all over-the-counter medications in the original containers.
District #145 does not provide over-the-counter medications for students use.**

I request/authorize SCHOOL DISTRICT 145 to give medication to my student in accordance with the instructions written above, from this date forward until the end of the current year unless otherwise notified. I understand that trained unlicensed staff may be assigned to provide medication to my student, and I accept ultimate responsibility for monitoring the effects of this medication.

Date _____ Parent/Guardian Signature _____

Home Phone _____

Work Phone _____

Cell Phone _____

*This form must be on file in the nurse's office before any OTC medication will be given to your child.