SCHOOL MEDICATION AUTHORIZATION for Over-the-counter medication:

STUDENT INFORMATION

Student's Name _____ **Date of Birth**_____

Grade _____ **Home Room Teacher** _____ **School Year** _____

List any known drug allergies/reactions _____ **Weight (lbs)** ____

MEDICATION INFORMATION

Name of Medication _____

Reason for Taking _____

Dosage _____ **Route** _____

Begin Medication _____ **Stop Medication** _____
Date **Date**

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) to delegate to unlicensed school personnel the task of assisting my child in taking the above medication when necessary. I understand that additional parent signed statements will be necessary if the dosage of medication is changed.

Medication must be registered with the school nurse. It must be in the **original**, unopened, sealed container and be properly labeled. The school nurse will not accept or administer any medication that is out of its original package/bottle.

_____ _____ _____
Signature of Parent **Date** **Phone**