**(SCHOOL NAME)**

**Authorization to Administer Medication at School**

**Student’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Over the Counter Medications (OTC), require parent/guardian initials and signature:**

**Authorized Over the Counter (OTC) Medications**, please initial the medications you give permission for your student to receive. (The dose given will be the dose recommended on the medication packaging unless your physician indicates otherwise.)

|  |  |
| --- | --- |
| \_\_\_\_   Ibuprofen  \_\_\_\_   Acetaminophen  \_\_\_\_   Tums  \_\_\_\_   Zyrtec | \_\_\_\_ Antibiotic Ointment (Bacitracin/Neosporin)  \_\_\_\_ Hydrocortisone Cream  \_\_\_\_ Cough Drops |

**Parent Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_\_

**Prescription AND additional OTC Medications require a signature from a prescribing health care provider AND a parent/guardian**:

**Medication**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dosage**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Route**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time(s) medication is to be given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Possible Side Effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Prescribing Healthcare Provider’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_               \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Health Care Provider with Prescriptive Authority                          Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent Signature       Date**

**(School) agrees to administer the above medications for the academic year as agreed to by the parent/guardian and/or as prescribed by a healthcare provider. Prescription medications must be provided to the school in an original pharmacy labeled container with the student's name, name of medication, time medication is to be given, dosage, date and licensed health care provider’s name.  Ask the pharmacist for a separate medicine bottle to keep at school, if necessary.  All over the counter (FDA approved) medications must be labeled with the student's name and be in original manufacturer’s packaging. Dosage must match the signed parental authorization.**