ST. MARY'S COUNTY PUBLIC SCHOOLS

Department of Student Services

OVER-THE-COUNTER MEDICATION AUTHORIZATION

I give permission for the school nurse/staff at _____ School to provide the following medication to my child as follows:

Student's Name: _____ Date of Birth: _____

Teacher: _____ Grade: _____

Name of Medication: _____

Dosage: _____ Frequency/Time: _____

Route (by mouth, topically, etc.): _____

Indications (Why is this being given?): _____

Notes: _____

_____

_____ _____

Signature of Parent/Legal Guardian Date

The OTC drug will not be given for more than two successive school days or more than two episodes during the school year without a physician's order.

The parent(s)/legal guardian(s) must give the first dose of the drug.

The OTC drug should be in an original container and brought to the school by the parent/legal guardian.

Medication may not be transported by students on the bus.

*Please refer to PS 400 or contact the school nurse for further information.

_____ _____

Signature of School Nurse Date

Administration Record Medication: _____

Date	Time	Dose	Initials