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: ___________________________

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<th>Date</th>
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