



OTC MEDICATION PERMISSION FORM

STUDENT'S NAME (PRINT): _____ BIRTH DATE: _____

LEGAL GUARDIAN: _____

DAYTIME PHONE: _____

NAME OF MEDICATION:

REASON FOR GIVEN MEDICATION AT SCHOOL. (PLEASE BE SPECIFIC):

AMOUNT OF MEDICATION TO BE GIVEN: _____

DATE TO START MEDICATION: _____ DATE TO STOP MEDICATION:

TIME OF DAY MEDICATION IS TO BE GIVEN: _____

EXPIRATION DATE OF MEDICATION: _____

POSSIBLE SIDE EFFECTS:

PARENTS: PLEASE READ CAREFULLY:

I understand that all medication will be provided by me in the original container, clearly labeled with my child's name. I will notify the school if the medication is discontinued or the dosage has been changed. Permission is granted to the administrator and/or school health official to share this information with individuals who have responsibility for my child. The first dose will be given at home so that I can monitor adverse reactions. I am responsible for replacing medication before the expiration date.

Legal Guardian Signature

Date

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PLEASE NOTE:

A SEPARATE PERMISSION FORM IS REQUIRED FOR EACH MEDICATION TO BE GIVEN. PARENTS ARE RESPONSIBLE FOR NOTING THE EXPIRATION DATE OF ALL MEDICATION. EXPIRED MEDICATION WILL NOT BE GIVEN AT SCHOOL ANY MEDICATION NOT PICKED UP BY THE LAST DAY OF SCHOOL WILL BE DESTROYED ACCORDING TO SCHOOL DISTRICT GUIDELINES.

Special Notes/Permission via Parent/Guardian:
