Authorization to Administer
Over-the-counter *(non-prescription)* Medication

Student ______________________________ Birth date ____________________

School ______________________ Grade __________ School Year ______________

Parent/Guardian 1: ______________ Parent/Guardian 2: ______________________

Daytime Phone (____) ______________ Daytime Phone (____) ______________________

Cell (____) ________________ Cell (____) ______________________

Authorization expires at the end of the school year or following the summer school session.

Parent/Guardian Consent:

I give permission for my son/daughter to receive the medication listed below. I also give permission for an exchange of information between school district personnel and the health care provider, if necessary, regarding this medication. I agree to notify the school in writing at the withdrawal of this request or when a change in this medication occurs.

I understand that it is my responsibility to:

- Transport the medication to school in the original container/packaging or container
- Replace the supply of medication when needed
- Pick up medication or direct staff to discard remaining medication upon discontinuation or at the end of the school year

Parent/Guardian Signature ______________________________ Date __________

Medication/Dosage	Route	Frequency	Start Date	Stop Date	Time to administer	Considerations/Side Effects
1.						
2.						

NOTE: A Physician Signature is required if:

-The medication is prescribed by a physician

-The medication exceeds the manufacturer's recommendation on package label

SAMPLES:

Dosage for Acetaminophen (mg) By Student Weight	36-47 lbs.	48-59 lbs.	60-71 lbs.	72-95 lbs.	96+ lbs.
160mg	1	2	2.5	3	4
325 mg	0	1	1	1.5	2
500mg	0	0	0	1	1

Dosage for Ibuprofen (mg) By student weight	>36 lbs.	>48 lbs.	>60 lbs.	>72 lbs.	>96lbs.
50mg	3	4	5	6	8
100mg	0	2	2.5	3	4
200mg	0	1	1	1.5	2

FOR SCHOOL USE ONLY

- Date received: ____________________________

- Name of person(s) who will administer the Medication:

  ______________________________ ______________________________

- Approved by: ________________________ ________________________
  (Principal's Signature) (Date)

- ________ Referred for administrative review. Send to School District Nurse with concerns about this authorization.