

Royalton Public Schools Medication Authorization Form 2A

OVER-THE-COUNTER MEDICATION AUTHORIZATION OF ADMINISTRATION OF MEDICATION

1. Over-the-counter medications and/or supplements may be administered to students at the discretion of school nurse.
 2. Written parent permission needs to be obtained.
 3. Parent needs to supply medication to school with proper label and dosage instructions.
 4. Dosage instructions will be based on label ONLY. If different instructions are needed than what is recommended on the label a physician order will need to be obtained.
 5. Acceptable over-the-counter medication are as follows; Tylenol (acetaminophen), Motrin (Ibuprofen, Advil).
 6. Cold/Cough medicines and cough drops will be acceptable however, only on a short term basis of 7 days. After which the school nurse will review with the parent as to how student's condition is improving or getting worse.
 7. Permission forms expire at the end of the school year and will need to be renewed at the beginning of the next school year.
 8. All medications need to be picked up by the last student day, after which will be destroyed by the school nurse.
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Students Name: _____ Date: _____ DOB: _____

Teacher: _____ Grade _____ School: _____

To Authorize School Personnel:

I hereby request and authorize you to administer:

Name of Medication: _____ Dose: _____

to the above listed student for the following reason: _____

Please include physician's name and phone number in case of an emergency:

Physician: _____ Phone Number: _____

Please include printed name and phone number in case of emergency:

Parent/Guardian _____ Phone Number _____

I request that this medication be given to my child as stated on label instructions and reason's listed above. I release the school personnel from any liability in the administration of the medication at school. **I understand that medication will not necessarily be administered by a school nurse.**

Parent Signature: _____ Date _____