Marshall County Central

Authorization for Administration of OTC Medication

School Year: _____

Student Name:	DOB:
Parent(s)/Guardian:	
Address:	
Phone # (please specify)	

Medication cannot be given for more than 1 week without a health provider's order. Please fill out Authorization for Administration of Medication from which includes a section for your health provider to fill out.

Medication Name	
Dosage needed in School (Dose cannot exceed manufacturer's instructions for age/weight)	
Time to be given in School	

Medication must be supplied in the original bottle with manufacturer's instructions.
Please label the bottle with your child's first and last name.
The bottle will be kept in the office and administered by staff.

I request and give my permission for school personnel to administer the above medication to my child. I understand this request is good for 1 week, after that a health provider's order will be needed to continue administration. The medication must be supplied in the original container with proper labeling. If my child is to self-administer this medication, additional forms will need to be filled out. These forms include a health provider's signature. I understand the school is not liable for any adverse reactions.

Signature of Parent/Guardian: _____ Date: _____

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE

Reviewed/Date _____