

**Over the Counter Medication
Parent Authorization**

Name of Student: _____ Date of Birth: _____

Parent/Guardian name (print) _____

Other person(s) to be notified in case of a medication emergency:

Name: _____ Telephone No. _____

My son/daughter is currently receiving the following medications: _____

Dosage: _____ Time(s) to be administered: _____

Purpose of the Medication: _____

Date to discontinue medication: _____

I request the above student receive this over-the-counter medication according to my parental request, and any special instructions.

I understand that over the counter medications cannot be given longer than three consecutive days without a physician's authorization. I understand the medication will be destroyed if it is not picked up within one week following termination of the order.

Parent/Guardian signature: _____ Date: _____