



CONFIDENTIAL

**OVER THE COUNTER MEDICATION
ADMINISTRATION /DISPERSAL
AUTHORIZATION**

Over the counter medications ***do not*** require a doctor's statement. All over the counter medications must be provided in original containers.

TO BE COMPLETED BY PARENT/GUARDIAN

Child's Name: _____ Male Female

Student ID: _____

Student's Date of Birth: _____ Grade: _____

Name of Over the Counter Medication to be Given:

1. _____
2. _____
3. _____

I request that my child be assisted in taking the over the counter medication(s), as described above, at school by authorized persons. Additionally, I am providing relevant medical information relating to the dispersal of the medications listed above. _____

_____ **Date** _____ **Parent/Guardian Signature** _____ **Home Phone** _____ **Emergency No.**