School Year:_____

Elder Grove School
Authorization for Occasional/Frequent Over the Counter Medication/Treatments

Name of Student: _____ Date of Birth: _____Grade: _____

Medication Allergies: _____

Over the Counter Medications

By initialing below, I give permission for school nurse/school personnel to administer the following medication (s) as needed to my student for minor discomfort or injury.

_____	Acetaminophen (i.e. Tylenol)	Dosage _____
_____	Ibuprofen (i.e. Advil or Motrin)	Dosage _____
_____	Antihistamine oral (i.e.Benadryl)	Dosage _____
_____	Antacid (i.e. Tums, Pepto)	Dosage _____

Parents may also supply other over the counter medications, please list below:

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____
Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

For frequent or daily use of over the counter medications:

- I will bring the medication to the school myself or by another responsible adult.
    - Students are not allowed to carry medication unless allowed to do so by law or specific school plan.
    - Students will not be given narcotic medications unless allowed by a specific school plan.
- I understand that over the counter medications must be brought to school in the original container with a label intact.
- I understand that I will also need to complete a medication drop off and pick up form regarding the above medication for drop off and pick up procedures.

Duration of Order: Valid until the end of school year unless otherwise noted.
Other length of duration: _____

_____	_____	_____	_____
Parent/Guardian Printed Name	Parent/Guardian Signature	Phone #	Date

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School Nurse Signature: _____ Date Order Reviewed:_____