Canton City School District
Health Services
Over the Counter Medication Authorization for Grades 6-12

Student Name_____ DOB_____

School_____ Grade_____ Teacher_____

Medication Allergies/ Interactions_____

This form must be completed fully, in order for schools to administer the required medication. A new OTC medication authorization form must be completed at the beginning of each school year, for each OTC medication, and each time there is a change in dosage or time of medication administration by the parent/guardian.

- ➔ Medication must be in its original container with the label intact and the student's first and last name clearly written on the bottle.
- ➔ A parent/guardian must bring the medication to school. Students are not permitted to bring medication to school.
- ➔ A parent/guardian must pick up the medication by the last day of school, or the medication will be disposed of.

PARENT / GUARDIAN OVER THE COUNTER MEDICATION AUTHORIZATION

I/We authorize designated school personnel to administer the medication as prescribed by the prescriber (below). I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that the ***medication must be in the original container*** and be properly labeled with the student's name, name of medication, dosage, strength, time interval, route of administration, and the date of drug expiration when appropriate. I/We understand that at the end of the school year, an adult must pick up the medication; otherwise it will be properly discarded.

Name of Medication_____

Medical Diagnosis and/or Symptoms for Medication_____

Dosage_____Route_____Frequency _____

Parent/Guardian Signature_____ Date _____

Contact Phone #1_____ Contact Phone #2 _____

RN (school) has reviewed this completed parent form. Sign_____Date _____