

**OVER-THE-COUNTER MEDS GIVEN DURING SCHOOL HOURS
PHYSICIAN AUTHORIZATION FORM**

i.e. Tylenol, Benedryl, Tums, Cough Drops, Cough Syrup, etc.

TO BE COMPLETED BY PHYSICIAN:

Name of Student: _____

Name of School: _____

Over-The-Counter Medication(s): _____

Reason for medication: _____

Significant Information: (include sided effects, toxic reactions, omission reactions: _____

Contraindications for Administration: _____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

- a. Contact me at my office: (Phone #) _____
- b. Take child immediately to the emergency room at _____
- c. Other option _____

This medication will be furnished by parent/guardian in the original container. Parents should add name of child, medication dispensed, dosage prescribed, and the time it is to be given.

Physician's Signature Date DEA #
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**TO BE COMPLETED BY PARENT: PARENT PERMISSION**

I hereby give permission for my child (named above) to receive medication during school hours. I understand that the school undertakes no responsibility for the administration of the medication. This medication has been authorized by a licensed physician. I hereby release the school and its agents and employees from any and all liability that may result from my child taking the prescribed medication.

\_\_\_\_\_  
Parent Name (Print) Phone

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_