ACCEPT
Education Collaborative

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PARENT/GUARDIAN AUTHORIZATION FOR DISPENSING NON-PRESCRIPTION MEDICATION 2016-2017 SCHOOL YEAR

Student: _____ DOB: _____ Allergies: _____

Certain over the counter medications, or the generic equivalent, are ordered by the school physician for student use. Please select from the following list the medications that you are authorizing for the school nurse to administer to your child:

□ Tylenol □ Motrin □ Benadryl □ Bacitracin □ Cough Drops □ TUMS

A student who needs to take **any other medication** during school hours must have this form signed by a parent/guardian and a signed **Medication Authorization and Administration Plan** from the prescribing physician. Medication must be in a pharmacy labeled container, and taken under the supervision of the school nurse. **Students are not allowed to transport any medication.**

My child currently takes the following medications at home:

Medication	Prescribed by:
_____	_____
_____	_____
_____	_____
_____	_____

Parent/Guardian:

Name _____ Signature _____

Phone Numbers _____ _____

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