# St. Mary's Springs Academy

## AUTHORIZATION TO ADMINISTER OVER-THE-COUNTER (NON-PRESCRIPTION) MEDICATION

Student:_____ Birthdate:_____ Grade:_____ School Year:_____

Parent/Guardian 1:_____ Parent/Guardian 2:_____

Daytime Phone: (_____)_____ Daytime Phone: (_____)_____

**Parent/Guardian Consent:** I give permission for my son/daughter to receive the medication listed below. I also give permission for an exchange of information between school personnel and the health care provider, if necessary, regarding this medication. I agree to notify the school in writing at the withdrawal of this request or when a change in this medication occurs. I understand that it is my responsibility to:

- Transport the medication to school in the original container/packaging or a pharmacy-labeled container (PK3-12th grade)
- Replace the supply of medication when needed
- Pick up medication or direct staff to discard remaining medication upon discontinuation or at the end of the school year

**Parent/Guardian Signature:** _____ **Date:** _____

NOTE: An *Authorization to Administer Prescribed Medication* form is required if:
▪ the medication dosage exceeds the manufacturer's recommendation **-OR-**
▪ a short-term prescription medication is needed for more than 2 weeks

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| **Reason:** | |
| **Name of Medication: (generic and trade)** | |
| **Dosage & Form of Medication:** | ☐ Tablet / Capsule ☐ Liquid mg / cc / tsp ☐ Eye / Ear / Nose Drops<br>☐ Ointment / Cream ☐ Other _____ |
| **Route:** | ☐ Oral ☐ Eyes ☐ Ear ☐ Nose ☐ Topical |
| **Time to be Administered:** | **As needed** – Describe frequency & symptoms for which medication should be given:<br>_____<br>_____<br>_____<br>_____<br>_____ |

****Authorization expires at the end of the school year.***

**FOR SCHOOL USE ONLY**

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| **Date Received:** | |
| **Name of Person(s) who will Administer Medication(s):** | |