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

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

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

FOR SCHOOL USE ONLY

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