EASTERN LOCAL SCHOOL DISTRICT HEALTH

PARENTAL AUTHORIZATION for ADMINISTRATION

OF OVER-THE-COUNTER MEDICATION to a STUDENT

Date: _____ Student Name: _____Grade: ____

Student Address: _____

_____ (student's name), has my permission to receive

_____(medication name) during school hours. Please

administer in the amount of _____ (# of tablets/amount of liquid) at the

following time/intervals _____ (time/hour). The administration of

this medication is to begin on _____(date) and continue through _____(date).

- Over-the-counter medication must be in the original container with the label intact and student's name written on outside of the container.
- An adult must bring the medication to the school.
- This form must be completed fully in order for the school to administer the above named medication.
- A new medication administration form must be completed for each medication and each time there is a change in dosage or time of administration of the medication.

I/We request designated school personnel to administer the medication as written above. I/We certify that I/we have legal authority to consent to the medication administration at the school for the student named above. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

____ Russellville Elementary ____ Sardinia Elementary ____ Eastern Middle School ____ Eastern High School

Please return this completed form to the student's school building office. Thank you.