PARK COUNTY SCHOOL DISTRICT #6
BOARD OF EDUCATION POLICY

MEDICATION AUTHORIZATION FORM FOR OVER-THE-COUNTER MEDICATION
(non-prescription)

I hereby give permission for the School Nurse or authorized school personnel to give:

Student's Name: _____

Allergies: _____ Date of Birth: _____

Medication: _____

Number of tablets: _____ or Teaspoons (liquid)_____

To be given every _____ hours

For what condition:_____

Duration: School year _____

How may days _____

How many weeks _____

Medication must be delivered to the school by the parent/guardian in the original manufacturer's container. All medications must be given according to the directions on the packaging. Dosing must be age appropriate.

_____ _____
Parent/Guardian Signature Date

Revised 5/2014