

## Parent Authorization of Administration of Medication at School

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_

I request/authorize the school to give medication to my child in accordance with the health care provider's instructions provided on the label of the medication. I understand that unlicensed staff may be assigned to provide medication to my child, and I accept ultimate responsibility for monitoring the effects of this medication.

Permission to carry inhaler Yes \_\_\_ No \_\_\_ N/A \_\_\_

Permission to self administer medication Yes \_\_\_ No \_\_\_

This is a non-prescription drug. Yes \_\_\_ No \_\_\_

Parents please note if this is a prescription drug we must have the ORIGINAL label and container of this medication in order to give this medication to your student. If this is a non-prescription drug, we must also have the **original container** in order to give the medication.

The following are the approved over-the-counter medications that may be administered at school. Please check yes or no as to whether your child may be given these medications.

Medication/ Dosage	Yes	No	Medication/ Dosage	Yes	No
Aspirin for Children (as directed for age)			Desitin ( as applied for need)		
Calpol ( as directed for age)			Neosporin ( as directed for age)		
Ibufen (as directed for age)			Fenistil Gel ( as applied for need)		
Peditus (as directed for age)			Ticture of Iodine ( as applied for need)		
Batticon Antiseptic Solution (must stay for 1-2 minutes after applied)			Hydrogen Peroxide ( as applied for need)		