Parental Authorization for Over the Counter Medication Administration 2020-21

Student's Name: ____ Birthdate: _______________ Grade: __________

Name of Medication: _________________________________ Dosage: ______________________ Route: _________

Time of Day to be Given: ____

Other Instructions: ____

I certify that I am the parent / legal guardian, of the above-identified student and authorize the school to administer the above-identified medication as indicated above for the 2020-2021 school year.

Parent Signature: ____ Date: __________

Date/Time: ____________________________ Dose: ___________________________ Signature: _________________________________

Date/Time: ____________________________ Dose: ___________________________ Signature: _________________________________

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Date/Time: ____________________________ Dose: ___________________________ Signature: _________________________________

Student's Name: _________________________Medication: __________________Dose: ____________

Date/Time: _____________________________ Dose: ____________________________ Signature: ___________________________________

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