



Permission for Administration of Over-the-Counter (OTC) Medication Not to Exceed Three Consecutive School Days

Instructions: This form is for OTC medications that do not need to be given for more than three school days in a row. Any non-prescription medication that is given for more than three (3) consecutive school days must be authorized in writing by a physician (see separate permission form). **Fill out an individual form for each OTC medication.** Examples of OTC medications: cough drops, ibuprofen, Tylenol, Neosporin, etc.

To Be Completed by Parent/Guardian

Student: _____ **Date of Birth:** ____ / ____ / ____

Allergies: _____

Name and Strength of Medication: _____

Dose (example: 5ml, 2 tablets): _____

Route (example: by mouth, topically): _____

Frequency (example: every 4-6 hours as needed): _____

Reason(s) medication is to be given: _____

Choose One:

This medication is for short term use (list dates to be given): _____

This permission form is valid for the duration of the current school year.

I, _____, the parent/legal guardian of _____,
Parent/Guardian Name Student Name

request that the school nurse, clinic attendant, or head of school's designee(s) administer the above medication to _____ during school hours.
Student Name

I agree to furnish this medication in its **ORIGINAL, UNOPENED container** with the label intact, and the student's name marked clearly on the package. I understand and accept that Northstar, its employees, agents, or designees are not responsible for any effects of the medication administered.

Signature of Parent/Guardian

Date