Permission for Administration of Over-the-Counter (OTC) Medication for More Than Three Consecutive School Days

Instructions: This form gives Northstar and Career Academy Staff permission to give an over-the-counter medication for more than three school days in a row, and/or a larger dose than what is recommended on the package/bottle. The Parent/Guardian must complete the top box, and the physician must complete the bottom box.

THIS FORM MUST HAVE A DOCTOR'S SIGNATURE

To Be Completed by the Parent/Guardian

Student Name: _____ Date of Birth: _____/_____/_____

Allergies: _____

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

that the school nurse, clinic attendant, or head of school's designee(s) administer the medication listed below to _____ during school hours. I agree to furnish this
Student's Name

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.

_____ _____
Parent/Legal Guardian Signature Date

To Be Completed by the Physician

I certify that, in my opinion, it is medically necessary for the medication listed below to be administered, as indicated below, to the above student during school hours, and that this medication may be administered by appropriately trained school personnel.

Diagnosis/Reason for medication: _____
Medication/Strength: _____
Dosage:_____ Route:_____ Frequency:_____
Duration: *(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.

_____ Licensed Prescriber Name (Please Print) _____ _____ Licensed Prescriber Signature Date	Licensed Prescriber Address/Phone: