Cedar Grove Belgium School District
MEDICATION AUTHORIZATION FORM
OVER-THE-COUNTER MEDICATION

Student Name____

Birthdate________________ Grade_________ Teacher/HR _____________________

Medication ____

Dose___________________________ Route/Mode of administration_____________

Time(s) to be given ___________ Start Date ____________ Stop Date ____________

Is this medication to be given every day? Yes No

Is this medication to be given only as needed? Yes No

If this medication is to be given only as needed, state condition/circumstances under which school personnel should administer medication.

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I hereby give permission for personnel designated by the principal or school nurse to give this medication to my child according to the directions stated. I also authorize school personnel designated in medication administration to contact my child's practitioner or me if there is a question regarding medication administration. I agree to notify the school when the drug is to be discontinued and/or the dosage or time changed. I understand that if the medication is resumed, a new medication authorization form is required. I understand that any unused medication will be properly disposed of within 10 days if not claimed after discontinuation of the medication or at the end of the school year.

Parent or Guardian Signature____

Home Phone _______________________ Work Phone ________________________

Date: ______________________________________

FAX: Elementary School 920-668-6933, Middle School 920-668-8566, High School 920-668-8605