MEDICINE AUTHORIZATION FORM

Student Name: _____ Grade: _____

Check all school-supplied medications which your child may take in the office as needed. Unless specified by the parent/guardian, dosages for these over-the-counter medications will be administered according to label instructions. No over-the-counter medications will be administered for more than five days in a row without a doctor's statement.

____ **Acetaminophen/Tylenol**
___ Children's Liquid ___ Adult tablet Preferred Dosage: _____

____ **Ibuprofen/Advil**
___ Children's Liquid ___ Adult tablet Preferred Dosage: _____

____ **Cough Drops**

____ **Tums**

List below any other medication that your child will need to take during the school day:

Medication: _____

Dosage: _____ Refrigerate? Y/N _____ Dosage time: _____

Special instructions: _____

Medication: _____

Dosage: _____ Refrigerate? Y/N _____ Dosage time: _____

Special instructions: _____

ATTENTION

If your child must take other <u>prescription</u> or <u>over-the-counter</u> medication during the school day, send the medication to school as follows:

- **Original packaging**
- **Parent note with dosing instructions**
- **Medication and note must be enclosed in plastic bag with student's name and grade written on it and sent to the school office**