# Jackson Local Schools

School Medication Administration Authorization Form

*Over-the-Counter Medication*

Student's Name:_____ DOB: _____

Grade:_____ Teacher:_____ School Year:_____

**This form must be completed fully, in order for schools to administer the over-the-counter medication. A new medication administration form must be completed for each medication, and each time there is a change in dosage or time of medication administration.**

- Non-prescription medication must be in the original packaging with the label intact and student's name.
- A parent/guardian **must** bring the medication to school. Students **are not** permitted to bring medication to school.
- Over-the-counter medication will only be given for **five (5)** consecutive school days. If the medication is needed for more than five days or if the medication is to be kept at school for the entire school year, the **School Medication Administration Authorization Form** must be completed by your child's primary care provider.
- Any unused medication must be picked up by the parent/guardian after 60 days or before the end of the school year, whichever occurs first; otherwise it will be properly discarded.

## ♦MEDICATION♦

Condition for which medication is being administered:_____

Medication name:_____ Time/frequency:_____

Strength:_____ Dose:_____ Total Amount:_____ Route:_____

Medication shall be administered from begin date: _____ to end date:_____

## ♦PARENT/GUARDIAN AUTHORIZATION♦

I/We request designated school personnel to administer over-the-counter medication as directed above. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that over-the-counter medication can only be given for a five (5) day period and that if my child needs this medication for a longer period of time that a medication order signed by a health care provider will be provided to the school. I/We understand that an adult must pick up any unused medication before the end of the school year; otherwise it will be properly discarded.

Parent/Guardian Signature:_____ Date:_____

Contact Phone #1:_____ Contact Phone #2:_____

Relationship to Student: ☐ parent ☐ legal guardian ☐ other: _____(needs written/verbal permission)

| Qty Rec'd | Parent Signature/Date | Staff Signature/Date | Qty Ret'd | Parent Signature/Date | Staff Signature/Date |
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**OTC Medication Administration Log**

| **date & time** / **staff initials** | | | | | |
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