HALLSVILLE SCHOOL DISTRICT

421 E. HIGHWAY 124
HALLSVILLE, MO 65255
PHONE (573) 696-5512
FAX (573) 696-3606

Authorization to Administer OTC Medication

Student Name _____

DOB _____ Current School Year/Grade Level _____ /_____

Family Physician/Clinic Name_____

My child has permission to receive the following "over-the-counter" medication, on an as needed basis (to be given under the supervision of the School Nurse and at the nurse's discretion). **I understand that before this can be administered, I am responsible for providing a small bottle of the medication specified below (in its original, unexpired, labeled container) to the School Nurse's office, labeled with my child's name.**

Please note: unless prior arrangements have been made, any medication remaining in the nurse's office at the end of the school year will be discarded.

I give permission for the exchange of verbal and/or written communication between the Physician's office and the School Nurse, regarding my child's medication regimen and the condition being treated.

___ Tylenol/acetaminophen (dosage to be given as directed on packaging label)
___ Advil/ibuprofen (dosage to be given as directed on packaging label)
____ Benadryl/diphenhydramine (dosage to be given as directed on packaging label)
___ Other _____
___ Other _____

_____ _____

Parent/Guardian Signature Date

_____ _____

School Nurse's Signature Date