SEMINOLE COUNTY PUBLIC SCHOOLS
AUTHORIZATION FOR OVER-THE-COUNTER
STUDENT ADMINISTERED MEDICATION

SECONDARY SCHOOLS ONLY

Student Name _____ School Year_____

School _____ Grade _____

My permission is hereby granted for my child to self-administer the following non-prescription medication during school hours and/or school activities.

Reason for which medication is required: _____

Name of medication: _____

Strength: _____ Dosage: _____ Route: ❒ Oral ❒ Inhaled ❒ Topical ❒ Other_____

How often will this medication be taken during the school day? _____

This authorization is valid for this school year only unless earlier date is specified: _____

****

Name of Parent/Legal Guardian (please print) _____ Date _____

Signature of Parent/Legal Guardian _____Relationship _____

Primary Phone_____ Other Phone _____

Note:

1. **Each medication requires a separate medication authorization form.**
2. All medication must be in the original container and clearly labeled with student's name.
3. The dosage must not exceed amounts recommended on the container label.
4. Parents who permit their child to self-administer over-the-counter medication assume full responsibility for any consequences resulting from the administration of the medication by their child.
5. **To maintain a safe and drug free environment, it is encouraged that the amount of medication carried by the student should not exceed the daily dosage.**

This form is to be turned into the school clinic and a copy should be carried by the student.