

PRESCRIPTION MEDICATIONS*

Name of medication: _____ Dosage of medication: _____

Medical condition/reason for medication: _____ Route: Oral Topical Ear Other: _____

Times to be administered at school/frequency: _____

Please note that medications to be given 3 times a day (example: antibiotic) should be given at home - before school, after school and before bed.

Times given at home: _____ Other medications given at home: _____

**Medications prescribed by a medical provider. Complete a separate form for each prescription medication.*Prescription medications must be FDA-approved, brought in the current prescription bottle with the pharmacy label intact and accompanied by parental/guardian permission (this completed/signed form) in order to be administered.

I hereby give consent for my child, the above named student, to take the above prescribed medication at school or on a field trip as directed by the physician. I give consent for the school to contact or exchange information as needed with my child's provider and/or pharmacy involved with the treatment of care. This information will be shared only with appropriate school personnel who need to know. If not picked up by parent, unused medication will be disposed of upon expiration of medication or at the end of the current school year, whichever comes first.

Parent/Guardian Signature: _____ Date: _____

The above named student requires the prescribed medication at school, to be given only as directed on the original, current prescription label on the container. I have reviewed discussed side effects with the student and/or guardian. I understand I may be contacted to clarify any dosing concerns.

Physician Signature: _____ Date: _____

Physician Printed Name: _____ Phone: _____

**George Little Rock Student Medication Authorization Form • School Year: _____
For Medication Brought From Home to be Given at School**

Student's Name: _____ DOB: _____ Grade: _____

OVER THE COUNTER (OTC) MEDICATIONS*

Name of medication: _____ Dosage of medication: _____

Reason for medication: _____ Route: Oral Topical Ear Other: _____

Times to be administered at school/frequency: _____ Dates to be given: _____

**This includes but is not limited to medications such as acetaminophen, ibuprofen, antacids, cough drops, cough syrup, antihistamines, pain gel, and ointments. Complete a separate form for each OTC medication.*

OTC medications must be FDA-approved, brought in the original bottle with label directions intact and accompanied by parental/guardian permission (this signed form) in order to be administered. Medication will only be given per label indication and dosed according to age/label instruction. If not picked up by parent, unused medication will be disposed of upon expiration of medication or at the end of the current school year, whichever comes first.

I hereby give consent for my child, the above named student, to take the above-described over the counter medication and authorize that they have not experienced side effects from this medication.

Parent/Guardian Signature: _____ Date: _____