Authorization for Administration of Over-the-Counter Medications at School

This form expires at the end of the current school year.

Student's Name_____

Street Address _____ Apt. No. _____

City_____ State_____ Zip _____

Date of Birth _____ School Year _____

As this student's parent/guardian, I give permission for my child to receive the following over-the-counter medications during school hours or during after-school activities. I agree to provide the medication my child needs in the original labeled container with the protective seal intact.

Over-the-Counter Medication
(Parent to Complete)

Medication	Circle Yes or	Circle No	Dosage	Time/Frequency
Acetaminophen (Tylenol) for headache, toothache or minor pain	Yes	No		
Ibuprofen for headache, toothache, minor pain or menstrual cramps	Yes	No		
Anti-itch cream or lotion	Yes	No		
Cough drops	Yes	No		
Tums (antacid)	Yes	No		

Is student allergic to any medications? □ No □ Yes, allergic to _____

Severe reactions that should be reported to the physician: _____

Student's Provider (Physician / Nurse Practitioner / Dentist)

Provider's Name: _____ Emergency Phone _____

I give permission to the Columbus Preparatory Academy's school nurse or Columbus Preparatory Academy's designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless the Columbus Preparatory Academy and its agents from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information.

_____ _____

Signature of Parent or Guardian Date

_____

Print Name of Parent or Guardian

How can we reach you during school hours?

_____ _____

Work Phone Cell Phone