BUENA VISTA CITY PUBLIC SCHOOLS
AUTHORIZATION TO ADMINISTER OVER THE COUNTER MEDICATIONS

If medication can be given at home or after school hours, please do so. However, if an over the counter medication must be given during school hours this form must be completed. Use one form for each medication.

****DO NOT USE THIS FORM FOR PRESCRIPTION MEDICATIONS****

Student Name:_____ Date of Birth: _____

Teacher:_____ Grade: _____

I request that_____School, through the principal or designee, assists in the administering of medication to my child, according to instructions below. I understand that:

- Medications must be transported by parent/guardian.
- Medications must be in the original labeled container (no baggies, foil, etc.)
- Parent/guardian must provide specific instructions, as well as the medication.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed.
- Unused medication will be disposed of unless picked up by the parent/guardian within 30 days after the authorization expires or on the last day of school.

Name of Medication: _____

Dose:_____Route (mouth, topical, etc.) _____

Time(s) to be given:_____Stop Medication on: _____

Condition/Illness Requiring Medication: _____

Known allergies: _____

Possible Side Effects, if any: _____

I hereby authorize the personnel of Buena Vista City Schools to administer my child an over the counter medication according to policy.
I understand that, in the event of a change in medicine, I am responsible for presenting a new request form.

Parent/Legal Guardian Signature:_____Date: _____

Home phone:_____Work phone:_____Cell phone: _____