SWEETWATER
UNION HIGH SCHOOL DISTRICT

Over-The-Counter (OTC) Medication Authorization Form

Student Name: _____ Date of Birth: _____ Grade: _____
Last First

Medication Allergies: No ☐ Yes ☐ If Yes, give name of medications(s): _____
Describe reaction: _____

Medications students may take while at school will be provided by parents/guardians. ***All medications brought to campus must be checked in with the School Nurse and listed on this form.*** Medications may be added or deleted from this authorization form at any time during the school year by contacting the School Nurse. With parental consent, the following types of OTC medications may be made available to your child when needed.

Please check "yes" to authorize school nurse/staff to give your child the following medications while on campus. *OTC medications are dispensed per package directions unless written directives are provided by a physician.*

Over-the-counter medication dispensed *per package* directions:	Indications:	Yes
Acetaminophen (Tylenol) or generic	Pain reliever/fever reducer	
Cough drops or throat lozenges	Cough/throat irritation	
Calcium Carbonate (Tums)	Stomach Pain	
Iboprofen (Advil) or generic	Pain Reliever/fever reducer	

Please add any other OTC medications you expect to provide for your child. Do not list prescription medications in this location. An authorization form from a physician is required for prescriptions.

Over-the-counter medication dispensed *per package* directions:	Indications:	Yes

I give permission for medication(s) listed above to be given to my child for self-administration at the Nurse's discretion or dispensed by designated personnel as delegated by the School Nurse.

_____ _____
Parent Signature Date

"Sweetwater Union High School District programs and activities shall be free from discrimination based on gender, sex, race, color, religion, ancestry, national origin, ethnic group identification, marital or parental status, physical or mental disability, sexual orientation or the perception of one or more of such characteristics."
SUHSD Board Policy 0410.

Medication/Reason	Dose	Date & Time	Supply	Nurse/Administrator Signature

OFFICE USE ONLY: List all medications in student's personal OTC supply kept in Health Office.

Date	Medication	Date	Medication

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