NELSON COUNTY SCHOOLS

Authorization to Give Over-the-Counter Medication

Over-the-counter medications will be given at school **only** with written permission from the child's physician and the child's parent(s) or legal guardian. The medication **must** be in the original container. Please ensure that your child's name is written somewhere on the medication. **Signed permission will expire at the end of the school year.**

Student's Name ____ **Date of Birth** ______________

This medication has been prescribed for my child by:

Physician's Name ____

Address ____

Phone ____

Physician's Signature ____

These instructions should be followed in giving my child this medicine:

Name of Medicine ____

Dosage ____

Time of day for dose ____

Possible reactions or side effects (list) ____

____

____

I give permission for myself/my child to receive the above medication at school and waive any liability on behalf of the school. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication. My signature will give permission for exchange of verbal and written communication between the Health Care Provider and the school nurse/health staff regarding my child's medical regime.

Signature of Parent or Legal Guardian ________________________________**Date** ______________

Home phone _________________________________

Work phone _________________________________

Cell phone __________________________________

Emergency contact name ____

Phone number ________________________________