AUTHORIZATION FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATION AT SCHOOL

Student Name _____ *Date of Birth* _____

Program _____ *School Year* _____ *Grade* _____

MEDICATION	ICD-10-CM CODE	PURPOSE	DOSE	TIME	POSSIBLE SIDE EFFECTS

☐ Student is knowledgeable about the medication and how to administer it.
☐ Student may self-administer the medication. (Not applicable for controlled substances.)

Other remarks:

_____

_____

Start Date _____ Stop Date _____
(All authorizations expire at the end of the school year or following the summer school session.)

PARENT/GUARDIAN AUTHORIZATION
I request that the above medication/treatment be administered to my student. I understand that I must provide medication in the original bottle, properly labeled by the manufacturer. I release school personnel from any liability in relation to the administration of this medication or treatment at school.

NOTE: MEDICATION MUST BE SUPPLIED IN ORIGINAL/PRESCRIPTION BOTTLE.

Parent/Guardian Signature _____ *Date* _____ *Relationship to Student* _____

Return to SWMetro Nurse
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SOUTHWEST METRO INTERMEDIATE DISTRICT 288