CONCORD COMMUNITY SCHOOLS

Authorization to Give Medication at School

Student Name: _____ **Teacher**: _____ **Grade**: _____ **Date of Birth:** _____

Name of Prescription Medication: _____
*(Medication must be provided in the **original container** and labeled with the student's name, the exact dosage, and time of administration.)*

Purpose: _____ **Dosage**: _____

Times to be administered at school: _____

_____ _____
Doctor's signature *Doctor's name printed*

****Grades K-8:** Medications must be brought to and picked up from school by a parent or an adult 18 or over and with written authorization from the parent. The pharmacy will provide a second bottle for school use if asked. Only topical type medication (as in eye/ear drops, creams, and ointments) may be sent to school and home with a student. These must be transported in a sealed envelope and need to follow all other guidelines.

Non-prescription medication will not be administered to a student unless written permission by the student's parent or guardian is on file at the school. The medications below are kept in stock and do not need to be provided by the parent. If you would like to have non-prescription medication given to your child during the school year, please complete this form, designate medications allowed below, and return it to the nurse. Please circle the preference.

Tylenol: YES or NO **Advil**: YES or NO **Benadryl** YES or NO
(for allergic reaction only)

All other non-prescription medication: _____
(Must be provided by the parent)

PARENT/GUARDIAN AUTHORIZATION

This certifies that I am aware of the above authorization and hereby request that appropriate school personnel carry it out accordingly. I agree to notify you immediately of any change in circumstance concerning the administration of this medication. I give permission for this information to be provided to the appropriate school personnel to best meet my student's health needs.

_____ _____
Parent/guardian name *Date*

** Grades 9-12 only: I give my permission for my student to transport the above medications home.

_____ _____
Parent/guardian name *Date*