ROSEDALE CHRISTIAN ACADEMY

Over the Counter Medication Administration Authorization Form

NOTE: If you elect to have any over the counter medication (OTC) given to your child during school hours or after school activities, this form is required to be completed and signed by you and the medical provider (doctor, physician assistant, nurse practitioner).

Please note that:

- This form is valid only for the school year (current): _____ including the summer session.
- This form must be completed fully and signed by both the parent/guardian and medical provider for the school to administer any over the counter (OTC)medication. A new form must be completed any time there is a change in dosage or time of administration of an OTC.
- With the parent/guardian signed authorization, below, the school nurse or certified medication technician (CMT) will call the prescriber, if allowed by HIPAA, with any questions that arises about your child and the OTC medication.

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

OVER THE COUNTER MEDICATIONS AVAILABLE AT ROSEDALE BAPTIST SCHOOL

Name of the OTC	Dose & Route	Time; Frequency	Reason Given	Side Effect(s), if any	Prescriber's Signature
Tylenol (Acetaminophen)					
Motrin (Ibuprofen)					
Tums (Antacid)					
Hydrocortisone					
Neosporin (Antibiotic Cream)					
Cough Drops					
Eye Relief (Eye Drops)					
Children's Benadryl					

Prescriber's Information

Prescriber's Name/Title: _____ Prescriber's Signature:_____

Address: _____ Phone: _____ Fax: _____

Parent/Guardian Authorization

I/we request designated school personnel to administer the over the medication, as prescribed, by the above prescriber. I/we authorize the school nurse or Certified Medication Technician to communicate with the health care provider, as allowed by HIPAA.

Parent/Guardian Signature:_____ **Date:** _____ **Home/Cell:**_____ **Work Phone:**_____