SCHOOL DISTRICT OF INDIAN RIVER COUNTY

2019-2020 MEDICATION AUTHORIZATION FORM

For Over-the-Counter (OTC) Medication

(Middle School and High School Students ONLY)

Instructions: Please return this completed form to the school health room.

Student's Name_____D.O.B._____Sex_____

School Name_____ Grade_____

Students Allergies_____

I grant permission to the principal or his/her designee to assist in the administration of this over-the-counter medication to my child while in school. I will supply the named medication in an unopened, original store-issued container. I understand that it is my responsibility to hand carry medication to the school health room. (**DO NOT send medication to school with your child.**) I understand that this agreement is valid until I terminate permission or until the end of the current school year. I understand that I will be notified when the medication is given. I understand that, according to F.S 1006.062, that there shall be no liability of civil damages as a result of the administration of the medication when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances.

***Reason for Medication:** _____

Mark only one box below. (No other medications have been approved.)

☐ **Acetaminophen (Tylenol) Regular Strength**	(One) **325mg** (regular strength) tablet every 4 hours as needed.
☐ **Acetaminophen (Tylenol) Regular Strength**	(Two) **325mg** (regular strength) tablets every 4 hours as needed.
☐ **Acetaminophen (Tylenol) Extra Strength**	(One) **500mg** tablet every 4 hours as needed.

Parent/Guardian Name (*print*) _____ Date: _____

Parent/Guardian (Signature required)_____Date: _____

Emergency Phone #_____Home Phone #_____

Business Phone #_____Cell Phone #_____

Physical Address_____

Medication request reviewed by Health Services RN or Health Department RN

Nurse's Signature_____Date:_____

Revised 02/19/2019