Permission Form for Over the Counter Medication

Grayson County Schools
School Health Services
Over the Counter Medication Authorization Form

Student's Name: _____ Date of Birth_____ Grade: _____

Homeroom/Classroom: _____ School Year: _____

To be completed by the Physician or School health services

Name of Medication: _____

Reason for Medication: _____

( ) Tablet/Capsule/Chewable ( ) Liquid ( )Topical ( ) Other _____

Instructions (Schedule and dose to be given at school): _____

Start: ( ) Date form received ( ) Other as specified: _____

Stop: ( ) End of school year ( ) Other date/duration: _____

Restrictions and/or important effects: ( ) No Restrictions

( ) Yes. Please describe:

_____

Special storage requirements: ( ) None ( ) Refrigerate ( ) Other

Physician/Authorized Provider Signature: _____

Date: _____

To Be Completed By School Health Services

Date Form Received: _____ School Health Services Signature: _____

To Be Completed By Parent/Guardian

I give my permission for my child to receive the above stated medication at school according to standard school policy. I release Grayson County Schools and its employees from any claims or liability connected with its reliance on this permission. **Parent/Guardian to bring medication in its original container.** *My signature will give permission for the exchange of verbal and written communication between the physician/authorized provider and the school nurse/health staff regarding my child's medication regimen.*

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Signature:	**Date:**	**Telephone:**