GOFFSTOWN SCHOOL DISTRICT
SCHOOL YEAR _____

PERMISSION TO ADMINISTER A PARENT PROVIDED OVER THE COUNTER (OTC) MEDICATION AT SCHOOL

STUDENT'S NAME _____Grade/Team/Graduation year_____

TEACHER'S NAME (if applicable)_____

MEDICATION NAME_____

DOSAGE OF MEDICATION WILL BE DETERMINED BY THE RECOMMENDED DOSAGE (height/weight if applicable) AND INSTRUCTIONS AS WRITTEN ON THE ORIGINAL BOTTLE. WE MAY NOT GIVE YOUR CHILD MORE MEDICINE THAN IS RECOMMENED FOR HIM/HER. If more than the recommended dose is needed we will require written permission from your child's physician.

TIME OF ADMINISTRATION _____

WILL THIS BE A DAILY MEDICATION (YES / NO). IF YES PLEASE PROVIDE BOTH A START AND STOP DATE. START_____ STOP_____

SPECIAL INSTRUCTIONS _____
_____

MEDICAL REASON FOR MEDICATION _____
_____
_____

EMERGENCY NUMBERS

1. Name_____
   Phone_____
2. Name_____
   Phone_____

*** ALL MEDICATION MUST BE IN THE ORIGINAL BOTTLE***
**** ADULTS (18 or over) NEED TO BRING MEDS TO THE SCHOOL****
*****IF MEDICATION IS TO BE GIVEN ON A REGULAR BASIS THEN A DOCTOR'S ORDER MAY BE REQUIRED*****

I hereby authorize the designated school staff person to administer the above OTC medication according to the original medication bottle's recommended dosage and instructions. I agree, by signing this statement that I will not hold liable SAU 19, the school nurse, or any other designated staff member for following the directions as printed on the above named medication bottle. I also agree, by signing this statement that if more than the recommended dosage of medication is needed that I will be required to provide written permission from my child's physician.

PARENT/GUARDIAN AUTHORIZATION:

SIGNATURE_____DATE_____