

**Plano Community Unit School District #88**  
**Over-the-Counter Medication Authorization Form – 2010-11**

***To be completed by parent/guardian:***

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

Emergency Phone No. \_\_\_\_\_

Name of Medication \_\_\_\_\_

Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

***Important Note: Nurse will not administer dosage above recommended amount or frequency on the label, without physician's authorization***

Time(s) to be given in school \_\_\_\_\_

Diagnosis requiring medication \_\_\_\_\_

Intended effect of this medication \_\_\_\_\_

Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition?

\_\_\_\_\_

Possible side effects, if any \_\_\_\_\_

I hereby grant permission for the above named school to issue medication as described above for the named child.

\_\_\_\_\_

Parent Signature

\_\_\_\_\_

Date

*Note: Please complete "Physician Prescribed Medication Authorization Form" if administration of medication is to exceed dosage or frequency on the package label.*

*Additional note: This form shall be effective for one school year.*