AUTHORIZATION FOR MEDICATION: Over-the-Counter Medication

Student's Name: _____Date of Birth: _____Grade: _____
School: CCS / CCHS

****

Allergies: _____

MEDICATION	DOSAGE & ROUTE	FREQUENCY	SPECIFIC TIMES	INDICATION FOR MED

****

_____ _____
Physician's Name **Physician's Telephone & Fax Numbers**

_____
Physician's Office Address

****

PARENTAL PERMISSION FOR MEDICATION

Student's Name: _____

Date of Birth: _____ Grade: __

I hereby give my permission to dispense the medication(s) listed above in accordance with written directions to my child when needed.

NOTE:

- **Medications must be supplied in the original container.**
- School personnel may administer only medications with written consent from parent/guardian.
- It is your responsibility to notify the school when there is a change in medication regimen.

_____ _____
Parent / Guardian Name (Printed) Signature of Parent / Guardian

_____ _____
Date Signed Home Phone Number

_____
Work/Cell Phone Number (Include Ext. if any)