

Plano Community Unit School District #88
Over-the-Counter Medication Authorization Form – 2009-10

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.