PARENT AND PHYSICIAN AUTHORIZATION FOR USE OF NON-PRESCRIPTION MEDICATION AT SCHOOL

DeKalb County School District

School Year 20___ to 20___

STUDENT________________________________ DATE OF BIRTH____________

SCHOOL___Margaret Harris Comprehensive______ DATE________________

All non-prescription (over-the-counter) medication must be approved by the parent/guardian *and* the student's physician in order to be given at school. Listed below are some of the non-prescription medications that might be needed during the school year. ***This form must be signed by the child's physician in order for these medications to be given at school.***

		Dosage (please complete)
Allergic Reaction	Benadryl	____________________
Cough	Robitussin	____________________
Fever/Pain	Tylenol	____________________
Fever/Pain	Ibuprofen	____________________
Nasal Congestion	Triaminic	____________________
Skin Abrasions	Polysporin Ointment	____________________
Dry skin/lips	Vaseline	____________________
Diaper rash	Desitin/A&D	____________________

If you would like to delete any of these non-prescription medications, please do so by drawing a line through that medication. List any additional non-prescription medications, with dosage, below and send medication to school with an adult.

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Signature of Practitioner Licensed to Prescribe **Date**

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I release the school board, the school, and any school employee from any liability for administering this medication. **Parents must supply all non-prescription medications.** Medications will be given only if needed. An attempt will be made to notify the parent before an over-the-counter medication is given.

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Parent Signature **Date**