OVER-THE-COUNTER (OTC) MEDICATION ADMINISTRATION AUTHORIZATION FORM
Over-the-Counter Medications

Student's Name _____ DOB _____

Who lives with parent/guardian at _____

In Nashua, New Hampshire 0306__

Teacher/Advisor _____ School _____ Grade _____

Name of Medication _____

We feel that our child may benefit from the following over-the-counter medications (not to include herbal preparations or dietary supplements) and wish to have an appropriate person assist our child in taking the medication furnished by us in accordance with the printed instruction on the manufacturer's labeled bottle we have provided. We understand that if a high dose than what the manufacturer recommends is needed, that a doctor's note, so authorizing the increased dosing will be provided by our child's medical provider or pediatrician.

_____ needed for _____

_____ needed for _____

_____ needed for _____

This permission is good for one school year unless otherwise specified for a specific condition lasting less than one (1) year.

HOLD HARMLESS: I hereby authorize the designated staff person or school nurse to administer the above medication as directed. In consideration for this service, I further agree that I will not hold liable, and will otherwise save harmless, the District and/or any department or employee thereof for death or injury resulting from administration or assistance in the administration of the medication described above. I understand that (a) not more than one month of prescribed medicine may be stored in school, (b) medication will be delivered directly to the School Nurse, Principal or designated staff member by the parent or guardian, if possible, and (c) the medication will be delivered in a container properly labeled with the student's name, the physician's name, the date of original prescription, name and strength of medication and directions for taking by the student.

Printed Name of parent/guardian _____

Signature of parent/guardian _____ Date _____

Yes No I give my permission for release/exchange of pertinent information by telephone, mail or electronic exchange including fax or email between the school nurse and the physician's office regarding the above medication.*

Yes No I give my permission for other school personnel to be notified of the medication and any adverse effects.*

**NOTE*: Included in the annual NSD Health History form

Signature of parent/guardian _____ Date _____