

Roswell Independent School District

**PARENT AUTHORIZATION TO ADMINISTER OVER THE COUNTER  
MEDICATION**

(One form per medication)

For medication to be safely administered at school every item on this form must be completed.

- Non prescription medication must be in the original unopened container.
- Students requiring non-prescription medication more than 3 times a month or on more than 3 days in a row will be referred for a medical evaluation.

STUDENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

DATE: \_\_\_\_\_ GRADE: \_\_\_\_\_

List all medication allergies: \_\_\_\_\_

**I authorize the School Nurse to administer the following medication to my child.**

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Route: \_\_\_\_\_ Time of Administration: \_\_\_\_\_

Reason: \_\_\_\_\_ How Long: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Initials: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Parent must initial any special directives added in the space below:**

_____	I will pick up any unused medication on the last day of school.
Parent Initials	
_____	Please send home any unused medication with my child on the last day of school.
Parent Initials	I assume all liability in the transport of the medication via my child. (NOT APPLICABLE FOR ELEMENTARY STUDENTS)
_____	Please discard any unused medication on the last day of school per Board of Pharmacy Regulations.
Parent Initials	