## **Baldwin-Woodville Area School District**



## Over The Counter Medication Request Form (Use separate authorization form for each medication and each student)

BWSD Board Policy 453.4-Exhibit 2

## TO BE COMPLETED BY PARENT/GUARDIAN

Name of Student:	Birthdate:	Grade:
Name of OTC medication:		
For the treatment of:		-
Specific dose(s) to be given at school:		
Time to be given at school:		
Start date: End date:		
Are there any special instructions ( ) No ( ) Yes, explain:		· · · · · · · · · · · · · · · · · · ·
Parent Signature and Information		
<ol> <li>I request this medication be given as prescribed by the manufa</li> <li>I understand I must provide this medication in the original manuame. I also understand that OTC medication will not be accep</li> <li>I will notify the school in writing when the medication is discon request that it be sent home with the student.</li> <li>I will pick up the medication at the end of the school year, or nattending summer school, I will pick up the medication by the I</li> <li>All products not currently approved by the FDA will only be addressed products included, but are not limited to, herbal and food</li> <li>I hereby give permission to designated school personnel to not and possible adverse effects of the medication.</li> <li>I give permission to contact the prescribing physician (#3) if the</li> </ol>	nufacturer's container and labe ited in a baggie or other non-na- tinued and I will pick up the un- equest it be sent home with the last day of summer school. ministered if ordered by a licenal supplements ie St. Johns Workify other school personnel of na-	nanufacturer container. nused medication or ne student. If my child is sed medical practitioner. t, etc. nedication administration
Parent/Guardian signature:	Date:	
Print Name:	Phone	