

**PARENTAL REQUEST AND AUTHORIZATION FOR  
THE ADMINISTRATION OF OVER THE COUNTER MEDICATION**

I am the parent/guardian/custodian of \_\_\_\_\_ (Student's full legal name)

Date of Birth \_\_\_\_\_ in the \_\_\_\_\_ School Building in Ogden

I request and authorize school personnel to administer the following medication to my child:

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

Commence Administration on: \_\_\_\_\_

Last Day of Administration: \_\_\_\_\_

Dosage, Time and Method of Administration: \_\_\_\_\_

---

Special Directions and Sign or Side Effects to Observe: \_\_\_\_\_

---

I understand that medication must be delivered to the school office in the original container.

I understand the request and authorization must be renewed each school year.

I agree to cooperate with school personnel if questions arise.

Final determination as to whether or not any medication will be administered by school personnel rests with the school's administration.

**PLEASE NOTE:** In the event of early dismissal 10:45 to 11:15 or before for weather related conditions, Medications will not be administered even if lunch is served. The nurse will not call to remind you. Please call Tammy Wirtz, District Nurse, if you have a concern.

\_\_\_\_\_  
Parent/Guardian/Custodian

Dated this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number