

**PARENT AND PHYSICIAN AUTHORIZATION FOR USE OF
NON-PRESCRIPTION MEDICATION AT SCHOOL
DeKalb County School System
School Year 20____ to 20____**

STUDENT _____ DATE OF BIRTH _____
SCHOOL _____ 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.***

		<u>Dosage (please complete)</u>
Allergic Reaction	Benadryl Syrup	_____
Fever/Pain	Tylenol Syrup	_____
Fever/Pain	Ibuprofen	_____
Skin Abrasions	Polysporin Ointment	_____
Dry skin/lips	Vaseline	_____
Diaper rash	Desitin	_____

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.

Signature of Practitioner Licensed to Prescribe

Date

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.

Parent Signature

Date