PORTER GAUD

Over-the-Counter Medication Authorization Form

to be completed by Parent or Guardian if needing OTC medication regularly

Permission is hereby granted to the designated employees of Porter-Gaud School to supervise my child in taking the following over-the-counter medication.

Name of student: _____

Date of birth: _____ Grade in 2016-2017: _____

Diagnosis: _____

Name of medication: _____

Dosage: _____

Route of administration: _____

Time(s) to be administered: _____

Possible side effects of medication: _____

Expected duration of need: _____

Other medications the student is taking concurrently: _____

Allergies to medications: _____

Comments / Specific instructions: _____

_____ _____ _____

Signature of Parent/Legal Guardian **Date** **Cell phone #**

Please return to: Porter-Gaud School
Email: nurse@portergaud.edu