

THE SCHOOL BOARD OF SARASOTA COUNTY, FLORIDA
and
FLORIDA DEPARTMENT OF HEALTH IN SARASOTA COUNTY
SCHOOL HEALTH SERVICES

MEDICATION AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION
MIDDLE SCHOOL AND HIGH SCHOOL STUDENTS ONLY

Instructions: Return this completed form to the school health room.

Student Name _____ DOB _____ Sex _____

School _____ School Year 20 ____ - 20 ____ Grade _____

List Child's Allergies _____

I grant permission to the principal or his/her designee to assist in the administration of over-the-counter medication to my child while in school and while participating in field trips. I will supply the named medication in an unopened, original store-issued container. I understand that it is my responsibility to hand carry medication to the school health room. **(Do not send medication to school with your child.)** I understand that this agreement is valid until I terminate permission or until the end of the current school year. I understand the law provides that there shall be no liability for civil damages as a result of the administration of such medication where the person administering such medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

Mark only one box below. **(No other medications have been approved.)**

<input type="checkbox"/> Tylenol or Acetaminophen	(One) <u>325 mg</u> (regular strength) tablet or <u>325 mg</u> chewable equivalent every 4 hours as needed (No liquid)
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Children must be 12 years of age or older for the medications listed below.

<input type="checkbox"/> Tylenol or Acetaminophen	(Two) <u>325 mg</u> (regular strength) tablets or <u>650 mg</u> chewable equivalent every 4 hours as needed (No liquid)
<input type="checkbox"/> Tylenol or Acetaminophen	(One) <u>500 mg</u> (extra-strength) tablet every 4 hours as needed
<input type="checkbox"/> Advil/Motrin or Ibuprofen	(One) <u>200 mg</u> (regular strength) tablet or <u>200 mg</u> chewable equivalent every 6 hours as needed (No liquid)
<input type="checkbox"/> Advil/Motrin or Ibuprofen	(Two) <u>200 mg</u> (regular strength) tablets or <u>400 mg</u> chewable equivalent every 6 hours as needed (No liquid)

Parent/Guardian Name _____

Emergency Phone No. _____ Home Phone No. _____

Work Phone No. _____ Cell Phone No. _____

Address _____
Street City State Zip

Parent/Guardian Signature _____ Date _____

Medication Order Reviewed By School RN Name _____

Date _____