SLIDELL INDEPENDENT SCHOOL DISTRICT

Over-the-Counter (OTC) Medication Authorization

Student Information

Student Name:	DOB:	Grade:
Campus:	Parent/Guardian Name:	Parent Phone:

Over-the-Counter Medication Information

Medication Name: _____

Dose: _____ Route: _____

Time (s) to be Administered at School: _____

Frequency: _____

Reason for Medication: _____

Special Instructions for School Staff: _____

Precautionary, if any: _____

Duration of Authorization (Example: Up to 3 school days): _____

Parent/Guardian Acknowledgment:

☐ Medication is in its original and not expired and labeled with my child's name.

☐ I have provided the correct dosage and instructions.

☐ I authorize Slidell ISD personnel to administer this medication according to district policy and Texas law.

☐ I understand medication will be stored in the health office unless otherwise permitted.

☐ I will notify the school nurse if my child's medication changes.

☐ I understand unused medication must be picked up. Medication not picked up before the end of school year may be disposed of according to district procedures.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____ Emergency Phone: _____

Healthcare Provider Order

Healthcare Provider: _____ Office Phone: _____ Fax: _____

Provider Signature: _____ Date: _____

Provider Instructions/PRN Parameters: _____

School Nurse Use Only

Medication Received: _____ Original Container Verified: ☐ Yes ☐ No Expiration: _____ Nurse Initials: _____