DEVINE INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICE DEPARTMENT

OVER-THE-COUNTER MEDICATION AUTHORIZATION FORM

Parent/Guardian Permission Slip Allowing DEVINE INDEPENDENT SCHOOL DISTRICT PERSONNEL to administer OVER-THE-COUNTER medication(s) that have been brought from home.

Student:_____ , _____ Grade: _____
Last First

Parent Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip:_____

Name of Medication: _____

Dosage: _____

Please Check on below:

- ☐ *Give Daily at* _____ *am / pm (circle one)*
- ☐ *Give only as needed every* _____ *hours*

Reason for medication _____

Side effects of medication _____

Further Instructions

_____

_____

Parent/Guardian Signature: _____ Date_____