AUTHORIZATION FOR OVER THE COUNTER MEDICATION OR TREATMENT

WILLIAMSBURG MIDDLE HIGH SCHOOL
500 South 5th Street Williamsburg, Ohio 45176
Phone 513-724-22111 Fax 513-724-6577

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NON PRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.

Student: _____DOB:_____

Address: _____

Date: _____

I am requesting permission for my child named above to:

- ❏ Use or receive the following over the counter medication(s)

  Medication: _____

  Dosage: _____

  Medication: _____

  Dosage: _____

- ❏ Self-administer such medication(s) in the presence of an authorized staff member

I will notify the school immediately if there is any change in the use of the medication or treatment.

Parent Signature: _____

Phone: _____

Physician Name: _____

Physician Phone: _____

Physician Signature: _____

AUTHORIZATION FOR STAFF
The following staff members are authorized to administer the above non prescribed medication(s)/treatments:

_____

_____