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 2024-2025: ________________

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