

*Jackson County Central Schools*

**Riverside**  
Phone (507)847-5963  
Fax (507)847-4398

**Pleasantview**  
Phone (507)662-6218  
Fax (507)662-6690

**Middle School**  
Phone (507)662-6625  
Fax (507)662-5063

**High School**  
Phone (507)847-5310  
Fax (507)847-3078

**Over-the-Counter Medication Administration Authorization Form**

**Student's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**School/Grade:** \_\_\_\_\_

**Student's approximate weight:** \_\_\_\_\_

**Parent/Guardian:** \_\_\_\_\_

**Daytime Phone Number:** \_\_\_\_\_

Parent/Guardian must complete this form for over-the-counter medications to be administered in school. Medications must be provided in original manufacturer container. Medications will only be administered to the student according to the label directions unless written directions from the physician are provided.

**I give permission for the following medication(s) to be administered by the appropriately designated personnel during school hours:**

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Medication	Reason for Use
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Medication	Reason for Use
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Medication	Reason for Use
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Additional information if necessary:

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This authorization will be valid for the length of the current school year unless otherwise stated by parent/guardian.

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

# Over-the-Counter Medication Administration Record

Student: \_\_\_\_\_

Student's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_

**Medication                      Date                      Time                      Reason                      Signature**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

8. \_\_\_\_\_

9. \_\_\_\_\_

10. \_\_\_\_\_

11. \_\_\_\_\_

12. \_\_\_\_\_

13. \_\_\_\_\_

14. \_\_\_\_\_

15. \_\_\_\_\_

16. \_\_\_\_\_

17. \_\_\_\_\_

18. \_\_\_\_\_