



**Howard-Suamico School District**  
Medication Request and  
Authorization Form  
**OTC MEDICATION**  
(Use a separate authorization form for each medication)

Student: \_\_\_\_\_ DOB: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_

**FOR COMPLETION BY PARENT/GUARDIAN FOR OTC MEDICATIONS**

Reason for medication: \_\_\_\_\_  
Name of Medication: \_\_\_\_\_  
Dosage: \_\_\_\_\_  
Start date of medication: \_\_\_\_\_ Stop date of medication: \_\_\_\_\_  
Administration:  As needed: Indication for use: \_\_\_\_\_  
If needed, how soon can administration of medication be repeated? \_\_\_\_\_  
Medication cannot be repeated more then: \_\_\_\_\_  
Side effects when contact should be made with you: \_\_\_\_\_

- A. Parent must deliver the medication to school in its original container.
- B. Parent will notify the school in writing immediately if there is any change in the use of the medication.
- C. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Phone #1: \_\_\_\_\_  
Phone #2: \_\_\_\_\_  
Parent/Guardian Name \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Parent: Return completed signed form to school office.*