OVERBROOK SCHOOL
MEDICATION AUTHORIZATION FORM

STUDENT INFORMATION

Student name_____
(Last) (First) (Middle)

Date of Birth_____ Homeroom teacher_____ Drug Allergies_____

_____

PRESCRIPTION MEDICATIONS

Name of drug:_____

Dosage and times at school:_____

Possible side effects:_____

PHYSICIAN SIGNATURE:_____ Date:_____

Please circle the **over the counter medication** you are providing and authorize the school to assist your child in taking. **We must have a doctor's order to give any of these medications in the school setting**.

Please assist my child in taking **Acetaminophen** for the following symptoms:
Dosage:_____ Frequency:_____

- ☐ fever
- ☐ muscle pain
- ☐ menstrual cramps
- ☐ headache
- ☐ sports injury

Please assist my child in taking **Ibuprofen** for the following symptoms:
Dosage:_____ Frequency:_____

- ☐ fever
- ☐ muscle pain
- ☐ menstrual cramps
- ☐ headache
- ☐ sports injury

PHYSICIAN SIGNATURE: _____ Date:_____

I hold Overbrook School harmless for any illness or injury resulting from following these instructions.

_____ _____
Parent Signature Date