Permission for Administration
of Over-the-Counter (OTC) Medication
Not to Exceed Three Consecutive School Days

Instructions: This form is for OTC medications that do not need to be given for more than three school days in a row. *Any non-prescription medication that is given for more than three (3) consecutive school days must be authorized in writing by a physician (see separate permission form).* Fill out an individual form for each OTC medication. Examples of OTC medications: cough drops, ibuprofen, Tylenol, Neosporin, etc.

To Be Completed by Parent/Guardian

Student: ____**Date of Birth:**___ / ___ /___
Allergies: ____

Name and Strength of Medication: ____

Dose (*example: 5ml, 2 tablets*): ____

Route *(example: by mouth, topically)*: ____

Frequency *(example: every 4-6 hours as needed)*: _________________________________

Reason(s) medication is to be given: ____

Choose One:
☐ This medication is for short term use (list dates to be given): _____________________
☐ This permission form is valid for the duration of the current school year.

I, _________________________, the parent/legal guardian of _________________________,
Parent/Guardian Name — Student Name
request that the school nurse, clinic attendant, or head of school's designee(s) administer

the above medication to _________________________ during school hours.
Student Name

I agree to furnish this medication in its **ORIGINAL, UNOPENED container** with the label intact, and the student's name marked clearly on the package. I understand and accept that Northstar Academy, its employees, agents, or designees are not responsible for any effects of the medication administered.

____ __________________________________
Signature of Parent/Guardian — Date

Northstar Academy 8055 Shrader Road Richmond, VA 23294
Phone (804) 747-1003; Fax (804) 747-1116; www.northstaracademy.net