

**AUTHORIZATION FOR OVER THE COUNTER MEDICATION OR TREATMENT**

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WILLIAMSBURG ELEMENTARY SCHOOL  
839 Spring Street Williamsburg, Ohio 45176  
Phone 513-724-2241 Fax 513-724-3902

**THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NON PRESCRIBED MEDICATIONS IN SCHOOL. ALL SPACES MUST BE COMPLETED.**

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

Address: \_\_\_\_\_

Date: \_\_\_\_\_

I am requesting permission for my child named above to:

- Use or receive the following over the counter medication(s)

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

- Self-administer such medication(s) in the presence of an authorized staff member

**I will notify the school immediately if there is any change in the use of the medication or treatment.**

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

Phone: \_\_\_\_\_

**Physician Name:** \_\_\_\_\_

**Physician Phone:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_

AUTHORIZATION FOR STAFF

The following staff members are authorized to administer the above non prescribed medication(s)/treatments:

\_\_\_\_\_

\_\_\_\_\_