

FOSTER-GLOCESTER REGIONAL SCHOOL DISTRICT

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OVER-THE-COUNTER MEDICATION AUTHORIZATION FORM

Over-the-Counter (OTC) medications are drugs that do not require a prescription and are purchased “over-the-counter.” This form is required before the medication listed below can be administered at school.

SCHOOL YEAR: _____

STUDENT NAME: _____

DATE OF BIRTH: _____ **GRADE:** _____

ADDRESS: _____

PHONE: _____

I, the parent/guardian of the above-named student, understand that special permission is required for the use of all medication by students during school hours. I request that my student be given the following over-the-counter medication described below as authorized by me:

Acetaminophen (Tylenol): YES ☐ NO ☐

Ibuprofen (Advil): YES ☐ NO ☐

I agree to hold the School District, its employees, and agents harmless in any and all claims arising from the administration of the above-chosen medication at school.

PARENT/GUARDIAN: _____
signature & date

Please complete this form and save as a PDF. You can upload this in the Document section of the Online Student Information Update. This information will only be shared with your School Nurse.

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