St. Cyprian's
HEALTH SERVICES

OVER THE COUNTER MEDICATION AUTHORIZATION

Student's Name:_____ DOB: ____/____/____ Homeroom:_____

I give my permission for SCES to give my child, _____, the following

MEDICATION: _____ DOSAGE: _____

WHEN TO GIVE: _____

START DATE: ____/____/____ END DATE: ____/____/____

****IMPORTANT"**End date 10 school days after start day, all unused said medication will be disposed of by the nurse after the end date.*

REASON FOR MEDICATION:_____

I hereby release St. Cyprian's Episcopal School from liability to allergy or reaction to said medication.

_____ ____/____/____

Parent or Guardian Signature Date

MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER WITH LABEL INTACT. The label must not be altered. Parent directions must match label directions. The dosage must be appropriate for your child's age.