Over the Counter Medication Authorization Form

School Year 2022-2023

Bay City Academy 301 N Farragut St Bay City MI 48708 989-414-8254 / Fax 989-321-2225

This order is valid only for the school year 2022-2023, including the summer session, for Bay City Academy.

Name of Student: _____ Date of Birth:_____
Grade: _____
Condition for which medication is being administered: _____
Medication Name:

_____ Tylenol Extra Strength Dose: _____
_____ Ibuprofen (Motrin) 200mg Dose: _____
_____ Tums Dose: _____
_____ Halls/Ludens(cough drops) Dose: _____
_____ Benadryl (Oral) Dose: _____
_____ Benadryl Cream for itching
_____ Neosporin Cream for wounds
_____ Other Please specify _____

Time/frequency of administration: _____
If PRN, frequency: _____ If PRN, for what symptoms:_____
Relevant side effects: □ None expected □ Specify: _____
Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: _____ Date: _____
Home Phone #: _____ Cell Phone #: _____
Work Phone #: _____

School RN approval for self carry/self administration of medication: _____

Signature_____ Date _____
Order reviewed by the school RN:
_____