

**Seymour Community Schools**  
**MEDICATION/TREATMENT AUTHORIZATION FORM**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**The following section is to be completed by the parent or legal guardian:**

List child's health condition and allergies: \_\_\_\_\_  
\_\_\_\_\_

Name of medication: \_\_\_\_\_  School supplied medication

Expiration date: \_\_\_\_\_ Amount to be given: \_\_\_\_\_ Time(s) to be given: \_\_\_\_\_

Date to start: \_\_\_\_\_  Date form signed      Date to end: \_\_\_\_\_  End of school year

Please initial below to give permission to administer the following school supplied medications and authorize administration with your signature below. Medication will be administered in accordance with school policy:

- |  |                                      |
|--|--------------------------------------|
| _____ Antacid                                  | _____ Pepto-Bismol                   |
| _____ Cough Drops                              | _____ Loradamed ( allergy medicine ) |
| _____ Ibuprofen ( <i>only ages 12 and up</i> ) |                                      |
| _____ Orajel                                   |                                      |
| _____ Sunscreen                                |                                      |
| _____ Triple Antibiotic Ointment               |                                      |
| _____ Tylenol                                  |                                      |

**Prescription medicine MUST have original, unaltered prescription label on the bottle; this label will include the child's name, medication, dosage, frequency of administration, doctor's name, pharmacy's name and phone number.**

**Non-prescription medicine MUST be in original (store labeled) container, also marked with the student's name. Medication dose cannot exceed dose specified on medication label without a physician's order. No Aspirin, aspirin products and/or naturopathic products will be given without a physician's order.**

I hereby grant permission to the school nurse, principal or the trained school-designated staff to assist in the administration of the prescribed medication and/or treatment to my child while in school and away from school while participating in official school activities.

Parent/Guardian Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_