SCHOOL DISTRICT OF
River Falls

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Over-the-Counter (OTC) Medication Authorization

Date:_____

Name of Student:_____DOB:_____

Grade:_____Teacher:_____

Allergies:_____

Student's Authorized Practioner:_____

Clinic's Location:_____

Medication Information:

Medication Name:_____Dose:_____

Frequency:_____ Time:_____Reason for Medication:_____

Medication Information:

Medication Name:_____Dose:_____

Frequency:_____ Time:_____Reason for Medication:_____

**** Medical provider signature is required if dose exceeds recommendations on packaging or if not recommended for student's age**

Parent Signature and Information:

1. I understand I must provide this medication in the original sealed container labeled clearly with the child's name.
2. I will provide only FDA approved over the counter medications. Examples of medications not FDA approved are but not limited to food supplements, herbal, and home remedies.
3. I will pick up the medication at the end of the school year, otherwise it will be disposed of by authorized school personnel.
4. If my child is attending summer school, I will pick up the medication by the last day of summer school.
5. I understand that medication orders must be renewed at the start of each school year.

Parent/Guardian Signature:_____ Date:_____

Print Name:_____ Phone: _____