

**Bay City Public Schools**  
**Over-The-Counter Medication Authorization Form (Med-2)**

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Teacher/Counselor \_\_\_\_\_ Grade \_\_\_\_\_ School Year \_\_\_\_\_

**To be completed by physician/licensed prescriber:**

	<u>Medication</u> (in original container)	<u>Dose</u>	<u>Time To be Given</u>	<u>Form/Route*</u>	<u>Possible Side Effects</u>	<u>Adverse Reactions</u> (Report to Parent)
<b>1</b>						
<b>2</b>						

\*Routes—oral (pill/capsule/chewable, liquid)—inhaled (inhaler, nebulizer)—topical skin application—topical (eye drop, ointment) -- topical ear drop—injection—other \_\_\_\_\_

Special Instructions \_\_\_\_\_

List symptoms/conditions under which medication ordered as needed (**p.r.n.**) is to be given: \_\_\_\_\_

If **p.r.n.**, MINIMUM amount of time between doses: \_\_\_\_\_

Reason for medication (optional): Medication #1 \_\_\_\_\_ Medication #2 \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Start date: \_\_\_\_\_ Stop date: \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_ Physician's Phone #: \_\_\_\_\_ Physician's Fax #: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Physician's Address \_\_\_\_\_ Date: \_\_\_\_\_

**To be completed by parent/guardian:**

I request and give permission for (name of child) \_\_\_\_\_ to receive the above medication(s) at school according to standard school district policy and for the physician's staff and school personnel to share relevant information regarding my child's medication needs

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_