

**Western Wayne Schools
Over-the-Counter Medication Authorization**

Over-the-counter medication or prescription medication to be given less than two weeks (such as an antibiotic) may not be administered to students without written authorization from a parent or legal guardian.

I hereby give permission for a staff member of Western Wayne Schools to administer the following medication:

Student: _____

**Medication, Dosage,
And Time to be given:** _____

Purpose medication is to be given: _____

Parent/Guardian Signature: _____

ALL OVER-THE-COUNTER MEDICATION MUST BE SENT IN BY PARENT/GUARDIAN. PLEASE SEND IN THE ORIGINAL CONTAINER WITH THIS COMPLETED FORM. WE DO NOT STOCK OVER-THE-COUNTER MEDICATION.

Date/Time Given:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature/Initials:

_____	_____
_____	_____
_____	_____
_____	_____

