

**AUTHORIZATION FOR ADMINISTRATION OF OTC MEDICINE BY  
SCHOOL PERSONNEL**

---

PIONEER REGIONAL SCHOOL CORP.

PHS PHONE 574-643-3145  
FAX 574-643-2020  
PIONEER ELEMENTARY 574-643-2255  
FAX 574-643-4029

Parents of students requesting OTC medication be administered during school hours by school staff are required to:

- 1) **complete** this form
- 2) supply medication in **original container**
- 3) frequency /dose must be **according to manufacturer's directions**
- 4) substances that are not FDA approved, will not be given

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade/H.Room \_\_\_\_\_

Medication \_\_\_\_\_

Dose \_\_\_\_\_ Time of Administration \_\_\_\_\_

If as needed, frequency \_\_\_\_\_ Allergies  No  Yes Specify \_\_\_\_\_

I request the above medication be administered by school personnel. I understand this medication will be destroyed if not picked up on the last day of school. To promote safety for your child, medication information may be shared with school personnel working with your child and with emergency personnel, if they are called.

Print Parent Name \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell/Work# \_\_\_\_\_