FOR OFFICE USE ONLY – DISTRIBUTION:
☐ School Office
☐ Main Office
☐ Homeroom: ________________________

Authorization for Administration of Over-the-Counter Medications at School – 2026-27

This form requires a Parent/Guardian signature. Expires at the end of the current school year.

Student Name:________________________ Date of Birth:____________ Home Phone:__________________

Street Address:________________________Apt #_______ City:_____________ State:_______ Zip:________

Also, please mark if your child is allergic to any of these medications.

Over-the-Counter Medication **available at the school first aid office*	**Ok to dispense?** ****please circle Yes or No***			**Provided by Parent/Guardian?**		**Dosage/ Mg**	**Time/ Frequency**
Acetaminophen (Tylenol) for headache, toothache, or minor pain	YES	NO	ALLERGIC?	YES	NO		
Ibuprofen (Motrin/Advil) for headache, toothache, minor pain or menstrual cramps	YES	NO	ALLERGIC?	YES	NO		
Anti-itch cream or lotion	YES	NO	ALLERGIC?	YES	NO		
Antibiotic Ointment for minor cuts, scrapes, etc.	YES	NO	ALLERGIC?	YES	NO		
Benadryl	YES	NO	ALLERGIC?	YES	NO		
Cough drops	YES	NO	ALLERGIC?	YES	NO		
Antacid (Tums)	YES	NO	ALLERGIC?	YES	NO		
OTHER – ***must be provided by Parent/Guardian, in original container and checked in by an adult at Main Office***:	**LIST MEDICATION:**						

*You will be informed when over-the-counter-medication is given to your child.

Severe reactions that should be reported to the staff: ____

As the parent/guardian of this student, I give my consent to Springer School & Center and its staff to administer the preceding medications to my child, in accordance with the special instructions which I have given herein and I, on behalf of myself, my child, heirs, executors, administrators, assigns, as well as my child's guardian(s) and other parent, do hereby fully release and discharge the Springer School & Center, its trustees, assigns and successors, employees and agents from all claims of damages and actions whatsoever, including medical and emergency expenses, arising from the giving of such medication. **I further understand that parents/guardians are required to hand deliver the child's medication to the main office in the original bottle and that medications will be stored in the school office depending on my child's medication schedule. I also understand that Springer staff cannot release medication to a child to carry home on his or her person.**
By signing, I hereby acknowledge receipt and understanding of the above policy.

Name of Parent/Guardian (please print): ____

Signature of Parent/Guardian: ____Date: ______________

How can we reach you during school hours?

Work phone: ________________ Home Phone: _______________ Cell Phone: ________________Other: _______________

REV. June 2026 KRM

☐ Updated Database ____________________