



SEMINOLE COUNTY PUBLIC SCHOOLS, FLORIDA  
AUTHORIZATION FOR OVER-THE-COUNTER  
STUDENT ADMINISTERED MEDICATION

SECONDARY SCHOOLS ONLY

Student Name \_\_\_\_\_ Date \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

My permission is hereby granted for the above named student to self-administer the following medication during school hours and/or school activities.

Name of Medication: \_\_\_\_\_

Strength: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: ρ Oral ρ Inhaled ρ Topical

Reason for which medication is required: \_\_\_\_\_

How often will this medication be taken during the school day: \_\_\_\_\_

This authorization is valid for this school year only unless earlier date is specified: \_\_\_\_\_  
(End Date)

Signature of Parent/Legal Guardian \_\_\_\_\_

Name of Parent/Legal Guardian (please print) \_\_\_\_\_

Relationship to Student \_\_\_\_\_

Home Phone \_\_\_\_\_ Business/Other Phone \_\_\_\_\_

- Note:**
1. All medication must be in the original container and clearly labeled with student's name.
  2. The dosage must not exceed amounts recommended on the container label.
  3. Parents who permit their child to self-administer over-the-counter medication assume full responsibility for any consequences resulting from the administration of the medication by their child.
  4. **To maintain a safe and drug free environment, it is encouraged that the amount of medication carried by the student should not exceed the daily dosage.**