

**Authorization for the School Nurse to administer prescription and over the counter medications in the school setting during the 2010-2011 school year**  
**Authorization for participation in physical education, sports and sports teams**

Name of Student \_\_\_\_\_ Grade \_\_\_\_\_

Consent for OTC medications to be administered by the school nurse *as needed*, please check off all that apply:

Tylenol \_\_\_\_\_ Benedryl allergy \_\_\_\_\_ antacid \_\_\_\_\_ other \_\_\_\_\_

**Prescription medications:**

Name of medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time of administration \_\_\_\_\_

Name of medication \_\_\_\_\_ Dosage \_\_\_\_\_ Time of administration \_\_\_\_\_

**Participation in sports activities, physical education and sports team activities**

Full physical activity \_\_\_\_\_ Restrictions \_\_\_\_\_

**Signatures (required)**

1) Parent \_\_\_\_\_ Date \_\_\_\_\_

2) Physician/NP signature \_\_\_\_\_ Date \_\_\_\_\_

Physician/NP name (please print) \_\_\_\_\_

Address of practice \_\_\_\_\_

Phone Number \_\_\_\_\_