



Rio Rancho Public Schools

AUTHORIZATION TO ADMINISTER OVER THE COUNTER MEDICATION (one form per medication)

DATE _____ GRADE _____

STUDENT _____ D.O.B. _____

I authorize the School Nurse or designee to administer the following medication to my student.

Medication _____

Amount _____

Time _____

Reason _____

Date Received _____ Expiration Date _____

Number Received _____ Nurse/HA Signature _____

Signed _____ Phone # _____
Parent or Guardian

MEDICATION MUST BE SUPPLIED TO THE HEALTH OFFICE IN THE ORIGINAL SEALED CONTAINER

Parents must initial any special directives added in the space below:

_____ I will pick up any unused medication on the last day of school.
(Parent initials)

_____ Please send home any unused medication with my child on the last day of school.
(Parent initials) I assume all liability in the transport of the medication via my child.
(NOT APPLICABLE FOR ELEMENTARY STUDENTS)

_____ Please discard any unused medication on the last day of school.
(Parent initials)

End of the year instructions