Academy of the Holy Family
54 W Main Street * P O Box 691 * Baltic CT * 06330-0691
(School) (860) 822-9272 * Fax (860) 822-1318
E-mail: schoolnurse@ahfbaltic.org

OVER-THE-COUNTER MEDICATION AND/OR NON ASPIRIN OR ASPIRIN SUBSTITUTES
AUTHORIZATION TO BE ADMINISTERED BY SCHOOL PERSONNEL

ALL INFORMATION MUST BE IN ENGLISH
Send Original forms must be sent to AHF, please keep a copy for your records.

The Connecticut State Law and Regulations requires a physician's written order and parent's/guardian's authorization for a nurse or in her absence, the principal or her designee to administer non-aspirin or aspirin substitutes or over-the-counter medication.
IF NEEDED during the current year: **20___ - 20___**.

Name of Student: (Print)_____ **Date of Birth:** _____/_____/_____
(Month/Day/Year)

Street/Mailing Address: _____

City State, Zip Code, Country_____

Over the counter medication authorization: I hereby give permission for the above named student to use over the counter medications and/or their generic equivalents as directed on the label. It is my understanding that the Academy of the Holy Family has standing medication administration & first aid directives in place signed by their School Physician.

Date(s) medication is to be administered: **From:**_____ **To:** _____

Please list any OTC/Topical medications that your daughter *MAY NOT* be given. If none are listed any/all standing ordered OTC medications &/or treatments may be used as appropriate.

_____ _____
NAME OF PARENT/GUARDIAN (Print) **Date**

_____ _____
SIGNATURE OF PARENT /GUARDIAN **Telephone #**