OVER THE COUNTER MEDICATION AUTHORIZATION FORM
DAKOTA SCHOOL DISTRICT 201

Student:_____ DOB:_____ Grad Year: _____

Please have your doctor fill out and sign the box below. If you wish to have your doctor fax over the order please ask them to include all requested information located in the box. Fax number for nurses office is (815) 449-2459. If you have any questions please call (844) 632-5682.

Medication:_____ Dosage:_____ Route:_____ Condition: _____ Please check one below: ☐ Valid while attending Dakota 201 ☐ Must renew each school year _____ Physician Name Printed _____ Physician Signature	Medication:_____ Dosage:_____ Route:_____ Condition: _____ Please check one below: ☐ Valid while attending Dakota 201 ☐ Must renew each school year _____ Physician Name Printed _____ Physician Signature

By signing below I give permission for the school nurse or those persons who have been properly trained, to administer medication(s).

_____ _____ _____

Parent/Guardian Name Parent/Guardian Signature Date

Medication Administration Record
DAKOTA CUSD #201

Administrator Name:	Date:	Time: