CENTRAL VALLEY
SCHOOL DISTRICT

PERMISSION FOR CARRYING OTC MEDICATIONS – *HS ONLY*

Student Name:_____ Birthdate: _____

School:_____ Grade: _____

Name of Medication	Dosage

THIS PORTION TO BE COMPLETED BY THE PARENT/GUARDIAN

I give permission for _____ to carry and self-administer this over-the-counter medication.

_____ **X**_____

Date of Signature Parent/Guardian Signature

Telephone Number: Home: _____ Work: _____

THIS PORTION TO BE COMPLETED BY THE PRINCIPAL AND/OR SCHOOL NURSE

The above named student may carry and self-administer this medication.

_____ **X**_____

Date of Signature Principal/School Nurse Signature

☐ **Copy given to student**

THIS FORM MUST BE COMPLETED ANNUALLY