AUTHORIZATION/PARENTAL CONSENT FOR ADMINISTERING **OVER-THE-COUNTER (NON-PRESCRIPTION) MEDICATION**

LCS
LYNCHBURG CITY SCHOOLS

Use a separate authorization form for each medication. New authorization required at the beginning of each school year.

Student Name _____ Date of Birth _____

School _____ School Year _____

Teacher/Homeroom _____ Grade _____

Medication Information

Medication Name: _____

Exact Dose to be Given: _____

Exact Beginning and Ending Dates (day/month/year): _____

Exact Time(s) to be Given: _____

Reason for Medication: _____

Medication Allergies: _____

Special Instructions: _____

Parent/Guardian Authorization & Consent

I, _____, parent/guardian of _____, request that the school nurse or designated school staff administer the over-the-counter medication listed above to my child. I authorize Lynchburg City Schools personnel to share information regarding this medication with the licensed prescriber as needed for safe administration. I understand that medication must be provided in accordance with Lynchburg City Schools procedures and applicable requirements.

Parent/Guardian Signature _____ Date _____

Emergency Contact _____ Primary Phone _____

Work/Alt. Phone _____ Emergency Phone _____

Medication must be provided in the original, unopened container and must be delivered directly to the school by the parent/guardian. Medication may not be sent to school with the student.

Medication Disposal: Any medication remaining at the school at the end of the school year must be picked up by the parent/guardian. Medication that is not picked up by the last day of school will be disposed of in accordance with Lynchburg City Schools procedures.

School Use Only

Date Received _____ Reviewed by _____

Revised 10/23/26