

Date: [Insert Date]

To: [Name of School/Organization/Facility]

Attention: [Name of Staff or Health Office]

# Over-The-Counter (OTC) Medication Authorization

I, [Parent/Guardian Name], hereby give permission to the staff of [Name of Organization] to administer the following over-the-counter medication(s) to my child/ward, [Child's Full Name], born on [Child's Date of Birth].

## Medication Details:

- **Medication Name:** [e.g., Ibuprofen, Acetaminophen]
- **Dosage:** [e.g., 200mg or as per label instructions]
- **Route:** [e.g., Oral]
- **Frequency/Timing:** [e.g., Every 6 hours as needed for headache]
- **Reason for Medication:** [e.g., Fever, pain relief, allergic reaction]

## Authorization Period:

This authorization is valid from [Start Date] to [End Date].

## Special Instructions/Precautions:

[Insert any allergies or specific instructions here, or write "None"]

I confirm that my child has previously taken this medication without any adverse reactions. I understand that it is my responsibility to provide the medication in its original, labeled container. I release [Name of Organization] and its employees from any liability regarding the administration of this medication as instructed.

## Emergency Contact Information:

Phone Number: [Insert Phone Number]

Email: [Insert Email Address]

Sincerely,

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[Parent/Guardian Signature]

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[Printed Name]