The Villages® Charter School

Over the Counter Headache Medication Authorization Form

SUMTER COUNTY SCHOOLS

Student Information

Student's Name

Date of Birth | Grade

School year | School

Parent/Guardian Name | Relationship to Student

Address

Home Phone | Emergency Phone | Cell Phone

List of Student Allergies

I hereby grant permission for my child, _____ , pursuant to Florida Statutes, 1002.20(3)(p), to possess and use a medication to relieve headaches while on school property or at a school-sponsored event or activity without a physician's note or prescription if the medication is regulated by the United States Food and Drug Administration for over-the-counter use to treat headaches.

I understand the Ibuprofen or Tylenol must be kept in the original container and students cannot share/distribute the medication. There will be disciplinary action for sharing/distributing medication. I understand that my child must follow school policies and procedures when taking the medication.

Parent/Legal Guardian Signature | **Date**

Parent/Legal Guardian (Print)

I understand, pursuant to Florida Statutes, 1002.20(3)(p), I can possess and use a medication to relieve headaches while on school property or at a school-sponsored event or activity without a physician's note or prescription if the medication is regulated by the United States Food and Drug Administration for over-the-counter use to treat headaches.

I understand the Ibuprofen or Tylenol must be kept in the original container and I cannot share/distribute the medication. There will be disciplinary action for sharing /distributing medication. I will follow my school's policies and procedures when taking the medication.

Student Signature | **Date**

This form must be completed each year and returned to the school clinic.

For School Use Only

Received By | **Date**

Signature