Over the Counter Headache Medication Authorization Form
Sumter County Schools

Please complete and return to the school clinic

Student Name: _____Grade: _____ DOB: _____

School Name: _____ School Year: _____

Parent/Guardian Name: _____ Relationship to Student: _____

Address: _____

Home Phone: _____ Emergency Phone: _____ Cell Phone: _____

List student allergies: _____

I hereby grant permission for my child, _____, per HB 1537, 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 medicine 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 my child must follow their school's policies and procedures when taking the medication.

Parent/Guardian Signature _____ Date: _____

Parent/Guardian Name (Print) : _____

I understand, per HB 1537, 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 medicine 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 _____