ST. MICHAEL THE ARCHANGEL HIGH SCHOOL
GENERIC (OVER THE COUNTER)
MEDICATION AUTHORIZATION FORM
2026-2027 School Year

Please complete, sign, and return this form to the school office by Friday, August 7, 2026.

Student Information

Student Name: _____
Grade: _____ Date of Birth: _____

Medication Authorization

I authorize St. Michael the Archangel High School personnel to administer the following over-the-counter medication(s) according to the manufacturer's labeled directions unless otherwise directed by a licensed healthcare provider.

- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Advil/Motrin)
- ☐ Naproxen (Aleve)
- ☐ Antacid (Tums)
- ☐ Pepto Bismal
- ☐ Cough Drops
- ☐ Diphenhydramine (Benadryl)
- ☐ Loratadine (Claritin)
- ☐ Cetirizine (Zyrtec)
- ☐ Hydrocortisone Cream
- ☐ Triple Antibiotic Ointment
- ☐ Aloe Vera Gel
- ☐ Other: _____

Allergies / Medical Conditions

Medication allergies:

_____

Medical conditions/restrictions:

_____

Parent/Guardian Authorization

- I understand medication will only be administered by authorized school personnel.
- I give the SMHS Athletic Trainer permission to give over-the-counter medications (checked above) as needed.
- I will provide medication in its original, unopened container labeled with my student's name.
- I am responsible for replacing expired or depleted medication.
- This authorization is valid for the current school year unless revoked in writing.

Parent/Guardian Name: _____

Signature: _____ Date: _____

Daytime Phone: _____ Emergency Phone: _____

School Use Only

Medication Received By: _____

Date Received: _____ Expiration Date: _____

Storage Location: _____

Notes:

_____

_____