AUTHORIZATION FOR OVER THE COUNTER (OTC) MEDICATION ADMINISTRATION IN SCHOOL

(To be renewed annually)

Student: ______________________Date of Birth: __________ Grade: _______ School Year: 2021-22

Parent/Guardian(s):____

School: Pioneer Elementary | Healy High School

Medication Location: Nurse office Self-carry (7-12 only – must sign agreement below)

Medication	**Dosage**	**Time**
Tylenol (Acetaminophen)	Per package directions	Every 4-6 hours as needed
☐ Benadryl (Diphenhydramine)	Per package directions	Every 4 -6 hours as needed
☐ Ibuprofen	Per package directions	Every 6 -8 hours as needed
☐ Other: _______________	______________________	________________________

PARENT/GUARDIAN AUTHORIZATION

1. I understand that OTC medications must be supplied by the parent/guardian in the **original container** with the proper label and dosage instructions.
2. Medication must NOT be expired.
3. Medications will be kept in the nurse office, unless self carry is indicated (7-12 only)
4. Medications not meeting the above guidelines will not be administered, and will be returned.
5. Field trips – I give permission the medication to be administered on a field trip, as necessary, following school procedure, by trained district staff.
6. I release all school personnel, ISD 484, and any responsible adult administering the medication, from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication(s).
7. All medications will be sent home on the last day of school with the above named student. Remaining medications will be taken to the Pierz Police Department for disposal.
8. I understand that cough medications containing pseudoephedrine **will not be administered**.
9. I understand that my written permission must be on file before any OTC medication will be administered.

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Parent/Guardian Signature Date

(7-12 ONLY) STUDENT OTC SELF CARRY AUTHORIZATION

1. I agree to follow label instructions on the medication bottle(s) for how much and how often I can take this medication
2. I understand I am only allowed to carry the medications listed above.
3. I will report to the school nurse if my symptoms do not improve within ONE hour after taking medication, or if I am experiencing a side effect of the medication.
4. I WILL NOT share these medications with any other students, under any circumstances.
5. I understand that if I do not adhere to these requirements my privilege to self-carry and self-administer may be revoked.
6. I understand that ultimately the school nurse and building administration retain the final decision to allow me to carry and administer my own medication.

_________________________________ __________________

Student Signature Date