Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade/Teacher \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Year \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exact Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time or Frequency of administration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Stop Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ End of School Year

□ Yes □ No My child would know if he/she has taken this medication at home before school.

□ Yes □ No This medication should be sent with on field trips and I give permission for a teacher/responsible adult to administer the medication. (If possible, consider sending tablet form of the medication as liquid is cumbersome to transport on field trips.)

**Parent/Guardian Authorization**

1. I have read the guidelines for the administration of over-the-counter medications at school. I give my permission for the above named medication (supplied by me) to be given by school staff as directed on this form.
2. I understand that all medication must be send in its original container/packaging. Medication in baggies will not be accepted.
3. I will immediately notify the school of any changes in the medication order.
4. I give permission for this information to be released to school personnel. (The information you provide will be shared only with staff in the school whose jobs require the information to ensure your child’s safety.)
5. I understand that I can refuse to share this information with other school staff by contacting the school nurse.
6. I release the school personnel and the school district from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.
7. I understand the school will not assume responsibility for medications that are self-administered.

Parent/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guidelines for parents regarding over-the-counter medication at school without an order from a physician/licensed prescriber:

* All medication must be in the **original** container.
* Medication will not be given if it has expired.
* Write the **exact dose** (amount of medication to be given, not a range).
* Write your child’s name on the medication bottle or packaging without covering the label.
* Only one medication per form. You will need a separate form for every medication.
* Write the **exact name** of the medication.
* Write the condition for use (headache, menstrual cramps, pain). Fever is NOT an appropriate condition for use. Children with fevers should be at home.
* Aspirin will not be given without a doctor’s order due to its association with Reye’s syndrome. The Consent for Prescription Medication form must be completed by health care provider.
* Medication will not be given beyond the dosage and frequently guidelines on the medication label without a doctor’s order.
* The very first dose of this medication should not be given at school since it is not known how your child may react to this medication.
* Unused medication may be picked up by a parent/guardian at any time. Medication remaining at the end of the school year will be properly discarded. Medication will not be sent home with students without parent/guardian permission.