NON-PRESCRIPTION MEDICATION
AUTHORIZATION FORM

This form is to be completed and signed by the parent/guardian authorizing medication to be given to the student during school hours. This form must be completed for non-prescription medications and returned to the school before the medicine can be given. All non-prescription medication must be in the original container and labelled with the child's name. If any changes occur during the school year, a new form must be completed and returned to school. This form is good for one school year.

Parent Permission Section (to be completed by parent/guardian)

Student _____ DOB _____ Gender _____

Teacher _____ Grade _____ School _____

Parent/Guardian _____ Phone _____

Emergency Contact _____ Phone _____

Physician's Name _____ Phone _____

The first dose of medication should always be given at home in case of an adverse reaction.

Please check the over-the-counter/non-prescription medication listed below that the school nurse may administer to your child according to the manufacturer's recommended dosage. It is understood that the medication (if available) is administered solely at the request of the parent and as an *accommodation*. Please check with the school nurse to see which medications are available for students in the school clinic and which medications you will need to supply. The school is not able to supply medication for frequent or daily use.

____ Acetaminophen/Tylenol ____ Antacids/Tums ____ Antibiotic/Bacitracin ointment
____ Benadryl/Diphenhydramine ____ Cough drops ____ Hydrocortisone cream 1%
____ Ibuprofen/Motrin
Other Medication: _____

_____

Dose _____Route _____Frequency _____

Allergies _____

If given as needed, describe/list indicators: _____

_____

Possible side effects _____

I understand that the Department of Education, its employees or agents shall not incur any liability as a result of any injury arising from the self-administration of the medication by my child, shall exempt from liability and hold harmless school employees or agents against any claims arising out of the self-administration of medication by my child, and I understand that this authorization shall be effective for this current school year and must be renewed annually.

We are required by law to maintain the privacy of your medical records. This privacy practice is adopted to ensure that the staff at Maryville City Schools protects your privacy. We consider it our duty to prevent unlawful disclosure of your medical records. Except as otherwise permitted or required by law, we will not use or disclose your health records without your written authorization.

Parent/Guardian Signature _____ Date _____