Medication Authorization Form: Over-the-Counter

Student Name: _____Birthdate/age: _____ Weight:_____

School: _____ School Fax: _____ Grade:_____

- No over-the-counter medication will be given to students without written permission from the parent, legal guardian, or a student who is 18 years old or older. Written consent for the over-the-counter medication is valid for one school year.
- The Elmbrook Health Rooms will supply generic Ibuprofen and generic Acetaminophen for use with completed form. All stock medications are available in tablet form, chewable tablets are available for children under 12 years. Stock medications will not be administered for more than 10 days per month without documentation from a practitioner.
- High School students may self-carry one day's dose of over-the-counter medication with this consent completed and on file in the health room.
- All medication must be non-expired and brought in from home in the original clearly labeled container. The medication will be stored in the locked cabinet in the health room.
- Medication will be given according to manufacturer's recommended dosages. If a student requires a dose which exceeds manufacturer's recommendations, a practitioner's order is required.

1. Please complete for STOCK Medications to be administered:

___ Ibuprofen 200mg 1-2 tablets, by mouth, every 4-6 hours as needed for discomfort (12 yrs & up)
___ Ibuprofen 300mg by mouth, every 6-8 hours as needed for discomfort 11-12 yrs (72-95#)
___ Ibuprofen 250mg by mouth, every 6-8 hours as needed for discomfort 9-10 yrs (60-71#)
___ Ibuprofen 200mg by mouth, every 6-8 hours as needed for discomfort 6-8 yrs (48-59#)
___ Ibuprofen 150mg by mouth, every 6-8 hours as needed for discomfort 4-5yrs (36-47#)
___ Ibuprofen 100mg by mouth, every 6-8 hours as needed for discomfort 2-3 yrs (24-35#)
___ Acetaminophen 325mg 2 tablets, by mouth, every 4-6 hours as needed for discomfort (>12yrs)
___ Acetaminophen 480mg, by mouth, every 4-6 hours as needed for discomfort 11-12 yrs (wt72-95#)
___ Acetaminophen 400mg, by mouth, every 4-6 hours as needed for discomfort 9-10 yrs (wt 60-71#)
___ Acetaminophen 320mg, by mouth, every 4-6 hours as needed for discomfort 6-8 yrs (wt 48-59#))
___ Acetaminophen 240mg, by mouth, every 4-6 hours as needed for discomfort 4-5 yrs (wt36-47#)
___ Acetaminophen 160mg, by mouth, every 4-6 hours as needed for discomfort 2-3 yrs (24-35#)

2. Over-the-Counter Medication below must be SUPPLIED BY PARENTS and will be stored in the Health Room:

Medication	Dose	Route	Time to be administered	Reason
1.				
2.				

___ Yes ___ No My high school student may self-carry one day's dose of the above medication(s)

I give consent for school personnel to administer the above listed medication/s. I agree to notify the school in writing at the termination of this request or when any changes in the above order is necessary. I understand that all unused medication will not be returned to my student unless authorized to self-carry. Parents must come to the Health Room for unused medication or it will be disposed of.

Parent/Guardian Signature:_____ Date:_____

(Office use only) School Nurse approval _____ Date: _____

Revised: April 2016

Medication Authorization Form: Prescription

Student Name: _____ Birthdate/age: _____

School: _____ School Fax: _____ Grade: _____

When it is necessary for a student to receive prescription medication at school:

- Written consent from the parent/guardian AND student's practitioner must be received before any medication is administered.
- Written practitioner's orders must be received stating:
    - A. Name of the medication
    - B. Dose
    - C. Route of medication (by mouth, eye drop/ear drops, IM injection, etc)
    - D. Time to be administered
    - E. Reason for the medication
- Written authorization for medication expires at the end of each school year, or earlier as directed by practitioner/parent.
- It is the responsibility of the parent/guardian to provide the Health Room with any changes to medication administration orders. The parent/guardian is also responsible for tracking and providing prescription medication to the health room as needed or when medication runs low.
- Staff may only administer medication as directed by the student's practitioner as is reflected on the medication administration form.
- The medication must be non-expired, and in a clearly labeled pharmacy container with the student's name, dosage and time to be administered on it.
- The prescription medication shall be securely stored in the Health Room.
- **Seizure medication orders** should be on the **Seizure Action Plan** form.
- **EpiPen/antihistamines for severe allergies** should be on the **Anaphylaxis Emergency Plan** form.
- **Asthma inhaler orders** should be on the **Asthma Management Care Plan** form.
- **Gastrostomy feeding orders** should be on the **G-Tube Feeding Health Care Plan** form.
- **Diabetes orders** should be on the **Diabetes Management Care Plan** form.
- Above forms can be found on the district website (student services/teaching and learning/health/forms) OR by contacting your student's health room.

Medication	Dose	Route	Time to be administered	Reason
1.				
2.				

I give consent for school personnel to administer the above listed medication/s. I agree to notify the school in writing the termination of this request and obtain any changes in writing from the prescribing practitioner. I understand that all unused medication will not be returned to my student unless authorized to self-carry. Parents must come to the Health Room for unused medication or it will be disposed of.

Parent/Guardian Signature: _____ Date: _____

Practitioner Printed Name: _____ Date: _____

Practitioner Signature: _____ Phone: _____

Fax: _____

(Office use only) School Nurse approval _____ Date: _____

Revised: April 2016