Ottawa Hills Local Schools

Over-the-Counter Medication Authorization

Student Name:_____ Date of Birth:_____

Address:_____ Building: ❑ Elem ❑ Jr/Sr High

Parent/Guardian Name(s):_____

Parent/Guardian Phone Number(s):_____

In accordance with Board Policy 5330 - Use of Medications: ..."Medication" shall include all medicines including those prescribed by a licensed health professional authorized to prescribe drugs and any nonprescribed (over-the-counter) drugs, preparations, and/or remedies. "Treatment" refers both to the manner in which a medication is administered and to health-care procedures which require special training, such as catheterization. Before any medication (i.e., a drug) or treatment may be administered to any student during school hours, the Board shall require a written statement from a licensed health professional authorized to prescribe drugs ("prescriber") accompanied by the written authorization of the parent. ...Parents may administer medication or treatment, with the exception of diabetes care covered under Policy 5336. Additionally, students may administer medication or treatment to themselves, if authorized in writing by their parents and a licensed health professional authorized to prescribe drugs but only in the presence of a designated school employee with the exception of students authorized to attend to their diabetes care and management pursuant to Policy 5336.

If you are sending prescription or over-the-counter medication, vitamins, supplements, etc., for your student then you must:

1. Indicate the type of medication(s), vitamins, supplements, etc., below;
2. Sign where indicated
3. Obtain your Doctor's signature.

IMPORTANT: You must ensure that all medications are FDA approved for use in this matter, properly labeled, and in their original containers.

SECTION 1: OVER-THE-COUNTER MEDICATION

Over-the-counter medication will NOT be administered without parent and physician signatures. The above named student is approved to take the following medications as needed, in accordance with directions on the packaging. Please check "Yes" or "No."

Student Age:_____ Student Weight:_____

Medication	As Needed for	YES	NO	Medication	As Needed For	YES	NO
Ibuprofen (Motrin/Advil)	Pain			Cough drop/Throat Lozenge	Cough or Sore Throat		
Acetaminophen (Tylenol)	Pain			Decongestant	Stuffy Nose		
Diphenhydramine (Benadryl)	Allergic Reaction/Rash			Antacid (Tums)	Upset Stomach		
Dramamine	Motion Sickness			Sunscreen	Sun Exposure		
Neosporin	Minor cuts, scrapes, burns			Other:			

SECTION 2: STUDENT RESTRICTIONS

Is there any reason for limiting or accommodating your student's activities? (e.g., injury, asthma, food allergies, etc.):_____

_____

Possible side effects that need to be reported to the parents or physician (e.g., allergic reaction):_____

_____

SECTION 3: PARENTAL CONSENT AND AUTHORIZATION

I/We, the undersigned, the parent(s)/guardian(s) of the above named student, request my student be assisted with or administered the medication listed above. I certify that I have legal authority to consent to medical treatment for the student names above. I release and agree to hold the Ottawa Hills Local Schools Board of Education, it's officials, and its employees harmless from any and all liability foreseeable and unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian Printed Name(s):_____

Parent/Guardian Signature(s):_____

Date:_____ Emergency Phone Number(s):_____

SECTION 4: PHYSICIAN SIGNATURE

My signature below provides the authorization for the above written orders.

Physician Printed Name:_____ Date:_____

Physician Signature:_____