Ashland Independent School District

Dear Parent/Guardian:

The Ashland Independent School District staff cannot administer any prescribed or over-the-counter medication to your child without the attached, signed consent forms (except for emergency First Aid). Please fill out and return the signed form(s) to school with your child as soon as possible. Please note that the consent for prescribed medication must be signed by your child's physician or health care provider, and any prescription medication that is to be given during the school day must be sent to the school in the original labeled container and the label shall include: name and address of the pharmacy, name of the patient, name of the prescribing doctor, expiration date, name of the medication, strength and dosage, route of the medication and frequency to be given. Medication not sent in the original labeled container will not be accepted per district policy. Labels that have been altered in any way will not be accepted. Changes in the dosage and/or times of administration must be received in the form of a written order from the physician/health care provider or a new prescription bottle from the pharmacy indicating the change and a note from the student's parent/guardian. All OTC and prescription medication must be signed in with the school nurse.

Over the counter medication may be accepted when a completed consent form to give medication is on file. The medication must be in the original container and will not be administered beyond its expiration date. Over the counter medication can be given no more than three consecutive days without written orders from a health care provider.

The consent can be withdrawn at any time by the parent or guardian, and is good only for the current school year.

Below is a list of the OTC medications our district school nurses have been approved to dispense with consent:

*Acetaminophen(Tylenol) dosed per weight
*Ibuprofen(Motrin) dosed per weight
*Neosporin
*1% Hydrocortisone cream
*Saline eye wash
*orasol anesthetic gel
*sore throat spray
*Bactine first aid antiseptic spray
*Band-Aid wound wash

Thank you,

Tiffany Callihan, R.N.

District Health Coordinator

Ashland Independent Schools

Permission Form for Over-The-Counter Medication

School: _____ Date form received: _____

Student's Name: _____ Grade: _____ Age: _____

Date of Birth: _____ Classroom: _____

To be completed by Parent/Guardian for non-prescription medications

As the parent or legal guardian of the student named below, I authorize my child to take the following over-the-counter medication as noted:

Name of medication:	Dosage / Schedule	Name of medication
IBUPROFEN	WEIGHT BASED	WOUND WASH
ACETAMINOPHEN(TYLENOL)	WEIGHT BASED	SALINE EYE WASH
1% HYDROCORTISONE CREAM	AS NEEDED	SORETHROAT SPRAY
TRIPLE ANTIBIOTIC OINT.(NEOSPORIN)	AS NEEDED	BACTINE ANTISEPTIC WOUND SPRAY
ORAJEL	AS NEEDED	

I give permission for (Student Name) _____ to receive the above medication(s) at school according to standard school policy and expressly hold harmless and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administrations of the above medication(s) unless such is the result of negligence or misconduct on behalf of the school or its employees. For ongoing medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the orders from a physician or health care provider to be followed.

Date: _____ Signature: _____ Relationship: _____

Home #: _____ Work #: _____ Emergency #: _____

To Be Completed by School Personnel

I/We acknowledge receipt of the foregoing statement and authorization Administrator/designee:

Name: _____ Date: _____