



**USD #385 Andover Public Schools
Department of Health Services
Over-the-Counter Medication Form
Grades PreK-5**

Name of Student: _____ Grade: _____ School: _____

Date of Birth: _____ Medication Allergies: _____

Current Medications: _____

Parents/Guardians of Andover School District students may choose to allow their child to receive over-the-counter medications in the school setting without a physician's signature.

Elementary Students, Grades PreK-5:

*All medications must be provided by parents and presented in the original unexpired age appropriate container and labeled for student use. Medications not received in an original age appropriate sealed container will not be administered. If a change in type of drug or dosage is warranted, a new form is to be completed by the parent/guardian and presented to the Health Office. All medications Must be PICKED UP by a parent or guardian from the Health Office before the last day of school.

Medication will be maintained in the nurse's office and dispensed **according to the label instructions for frequency and dosage per age** and at the discretion of the Registered Nurse.

Consent to Administer Over-the-Counter Medication in the School Setting:

I understand that the Registered Nurse employed by USD 385 must have written parent/guardian consent before any medication can be administered at school. I hereby certify that my child, _____ has previously had at least one dose of the medication(s) requested. I understand that any school employee who administers this medication to my child, will do so in accordance with USD 385 Board of Education Policy and the Practice Act of the Kansas State Board of Nursing, and shall not be liable for damages as a result of an adverse drug reaction suffered by the student. I hereby give permission for my child to be administered the following over-the-counter medications during this school year and for my student's weight to be obtained as needed in order to calculate accurate recommended dosage:

_____ Acetaminophen-Generic Tylenol

_____ Ibuprofen-Generic Advil

_____ Cough drops

_____ Triple Antibiotic Ointment (minor cuts and scrapes only)

_____ Anti-itch cream : Hydrocortisone 1% only, Caladryl/Calamine lotion (anti- itch for bug bites, poison ivy, minor rash areas)

_____ Diphenhydramine - Generic Benadryl

_____ Other non-prescription medications _____

All prescription medications require written permission of the parent/guardian and physician for administration in the school setting. USD #385 Prescription Medication Form is available on the Andover Public School website under Nurses Corner: Medications at School. All controlled substances defined as such under state or federal law will be kept in locked cabinets under the supervision of the Registered Nurse. Students who retain controlled substances on their person on school grounds are subject to the disciplinary policies of USD #385.

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____