ISD 482

Little Falls Community Schools

Over-the-Counter (OTC)

Medication Administration Authorization Form

****This authorization is only valid for the current school year**.**

1. Medications must be provided by parent/guardian. School district will **NOT** provide any medications.
2. With this completed form, student **may** be allowed to carry and self-administer medications listed below.
3. Student's supply of medication **must** be in the original container with proper label and dosage instructions. Medication must NOT be expired.
4. If parent/guardian request dosing instructions that differ from what is on the medication bottle label, a physician order will need to be obtained and it will then be considered a prescription medication.
5. Acceptable OTC medications include: acetaminophen (Tylenol), ibuprofen (Advil, Motrin), naproxen (Aleve), antacids (Tums, Pepto Bismol), Lactaid, Pamprin/Midol.
6. Cold/cough medicine (only those that do NOT contain ephedrine or pseudoephedrine) will be acceptable on a short-term basis of 7 days, after which the school nurse will review with the parent/guardian the student's condition and discuss further need of medication.
7. OTC medications in the nurse's office will be sent home with the student on the last day of school, any remaining medications will be delivered to the LFPD to be disposed of lawfully.
8. Approved ISD #482 school personnel administering medication are released from any and all liability in the event of any adverse reaction resulting from the use or administration of the below medications.
9. School nurse and building administration retain final decision to allow student (grades 6-12 only) to carry and self-administer medication and may revoke student's privilege to carry/self-administer at any time, at which time the student's medication would be kept in the nurse's office and administered by school staff.

Parent Request for OTC Medication Administration in School

Student Name: _____ Date of birth: ____/____/___

1. Medication: _____
2. Medication: _____
3. Medication: _____
4. Medication: _____

___I have read the above requirements for OTC medications in school.
___I have read the "Student Agreement" below and understand my child's role in carrying and self-administering OTC medications.
___I understand that my child's privilege to carry and self-administer these medications may be removed if my child fails to follow this agreement.

*****Please select only one of the following options*****

___**I give permission for my above named child to carry and self-administer** the listed medications. It is in my best judgment that my child is capable of following administration directions listed on the medication bottle.
___**I request that the above OTC medication be kept in the nurse's office** and administered by school staff. I understand that the medication will be administered according to medication label instructions.

My child is allergic to the following medications:_____

Parent/Guardian Printed Name: _____ Signature_____
Phone: (c) _____Phone: (h) _____ Date: _____/_____/_____

Student Agreement for Self-Administered OTC Medication in School

___I understand that self-administration and the ability to carry my OTC medication at school is a privilege and not a right.
___I agree to follow label instructions on the medication bottle(s) listed above for how much and how often I can take this medication and understand that I only have permission to carry and self-administer the medication(s) listed above.
___I will report to the school nurse if my symptoms do not improve within one hour of taking the medication or if they return before I am able to take another dose (as directed on medication label instructions).
___I will report to the school nurse if I feel I am experiencing side effects of the medication.
___The school nurse has reviewed medication instructions with me and I understand how to properly self-administer the medication(s).
___I WILL NOT share, borrow or distribute these medications with or from any student, under any circumstance.
___I understand that if I do not follow these instructions, my privilege to carry and self-administer the above OTC medications may be revoked.

Student Signature: _____ Date: ____/____/____