Lee County Schools / Student Health Services

Authorization for Students to *Carry Approved Over-the-Counter* Medication

STUDENT NAME:	HR/TEAM:	GRADE:	DOB:

To Be Completed by Parent/Guardian

I hereby request that the above named student, over whom I have legal guardianship, be allowed to carry and use the following medication(s) at school:

▢ **acetaminophen** ▢ **ibuprofen** ▢ **cough/throat lozenges** ▢ **Midol** ▢ **Tums**
▢ **oral/topical antihistamine** ▢ **hydrocortisone cream** ▢ **Other: _____**

- I understand that my student may only take medication in accordance with the label directions.
- I accept legal responsibility should the medication be lost, or taken by a person other than the above named student. I understand that if this happens, the privilege of carrying the medication may be reassessed and/or revoked, and the student may be subject to disciplinary action.
- OTC Medication shall be sent with the student in the original manufacturer's container.
  The manufacturer's label must include:
  a. Name of the medication, either brand or generic;
  b. Strength of the medication;
  c. Instructions for use; and
  d. Name of the student, legibly written.
- A copy of this completed form must be kept with the medication and provided to any staff member upon request.
- I release Lee County School System (LCSS) and its employees of any legal responsibility when supervising or assisting in this medication administration or when the above named student administers his/her own medication (to include choking, allergic reaction, side effects and/or health risks related to this medication).
- Pursuant to LCSS Medication Administration Policy:
  - 3-5th graders may carry the following over-the-counter medications with the completion of this form: *cough/throat lozenges, topical creams/ointments*
  - 6-8th graders may carry the following over-the-counter medications with the completion of this form: *acetaminophen, antacids, cough/throat lozenges, ibuprofen, Midol or oral/topical antihistamines*
  - 9-12th graders may also carry these approved medications but no form is required
  - All medications must be kept in the original containers

_____ _____

Parent/Guardian Signature *Date*

To Be Completed by Student

- I have been instructed in the proper use of the above named medication(s) and fully understand the label directions.
- I will keep the medication(s) and a copy of this completed form with me at all times and present it to any staff member who requests to see it.
- I will not allow another student to use my medication under any circumstances. I also understand that should another student use my over-the-counter medication, the privilege of carrying my medication may be reassessed and/or revoked and I may be subject to disciplinary action.

_____ _____

Student Signature *Date*