SCHOOL DISTRICT OF LODI

District Office	High School	Middle School	Elementary School	Primary School
115 School Street	1100 Sauk Street	900 Sauk Street	101 School Street	1307 Sauk Street
608-592-3851	608-592-3853	608-592-3854	608-592-3842	608-592-3855
Fax: 608-592-3852	Fax: 608-592-1045	Fax: 608-592-1035	Fax: 608-592-1025	Fax: 608-592-1015

NON-PRESCRIPTION/OVER-THE-COUNTER MEDICATION FORM

Medications are to be given at home, whenever possible. If it is necessary for a student to receive medications at school, all appropriate portions of this form **MUST** be completed before a medication can be given at school. **For PRESCRPITION MEDICATION, please fill out the prescription medication form.**

Parent may allow over-the-counter medications **ONLY if they are within therapeutic dose as labeled on medication packaging for your child's age and/or weight**. If the desired medication is above the therapeutic dosage allowed per packaging or there are additional safety concerns regarding the medication, the school may request that a health care practitioner reviewed and authorized in writing the administration of the medication.

Student Name:_____**School:**_____**Grade:**_____

Date of Birth:_____ **Age:**_____ **Weight:** _____

Medication Name:	Route	Dose	Frequency /Time	Start date	End date	Possible Side effects:

We have some stock medications in the nurse's office. If you want your student to be able to use these medications at school, please check yes.

[] Yes [] No Hydrocortisone Cream 1% - for rash
[] Yes [] No Triple Antibiotic Cream- for minor scrapes and cuts.
[] Yes [] No Cough drop: containing menthol- for sore throat or cough
[] Yes [] No Sting relief: Lidocaine 2.0% and Ethyl Alcohol 50%- for Bee stings and other stinging/ biting insects
[] Yes [] No Burn Cream: Lidocaine 0.5% and Benzalkonium 0.13%- For small first or second-degree burns

PARENT/GUARDIAN CONSENT:

REQUIRED SIGNATURES

I have read the medication policy and understand my parent responsibilities in providing my child this medication at school. The above medication is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication and understand the medication will be given by non-medically trained school personnel.

Parent/Guardian Signature:_____ **Date:**___/___/___

Date Received at School: _____/_____/_____ Received by:_____

Approved by School Board April 2023