Hillsboro City Schools
Elementary- (937) 393-3132 Fax- (937) 393-2418
MS/HS- (937) 393-4421 Fax- (937) 393-5843

Over-the-Counter Medication

Dear Parents/Guardians,

In order for your student to take over-the-counter medication at school, the following procedures must be followed:

1. The parent/guardian must complete and sign the Over-the-Counter medication form.
2. Medications must be delivered to the clinic staff by a responsible adult.
3. The medication must be delivered in the **original**, **unopened** container.
4. Medications must be stored and locked in the clinic. Students are **not permitted** to keep any medication with them or in their locker (except for asthma inhalers or auto-injector epinephrine, provided the appropriate forms have been completed and the student requirements have been met).
5. Students must take their medication in the clinic.
6. Each medication must have a separate form.
7. Clinic staff can only give the dose recommended on the bottle for the age of the student, unless we have an order from a physician.
8. Aspirin cannot be administered without a physician's order because of it's association with Reye's Syndrome.

If there are changes in the medication, dose, or instructions, a NEW form must be completed. A new medication form is required EVERY school year.

These policies are for the health and safety of your child. If you have any questions, please contact the school nurse.

School Nurse
Katie Greer, RN, BSN

Hillsboro City Schools

Elementary- (937) 393-3132 Fax- (937) 393-2418
MS/HS- (937) 393-4421 Fax- (937) 393-5843

Over-the-Counter Medication Form

I, the parent/guardian of the student listed, hereby request and give permission to the Board-approved personnel to administer the over the counter medication listed below.

Name of student: _____

Grade: _____ Teacher: _____

Name of medication: _____

Dosage: _____ Specific time(s): _____

****Dose and times may not exceed the package instructions****

Reason for use: _____

_____

Starting date: _____ Ending date: _____

I agree:

1. To store medication in the clinic in the original container.
2. To instruct my child to take the medication in the clinic.
3. To submit a new Medication Form if the medication, dosage, or instructions change.

I have read and understand the policy for administration of over-the-counter medication and request that the above listed medication be administered by school personnel at school. Because school personnel are not legally obligated to administer medication to any student, I further acknowledge that by signing this form, I release all Board-designated school employees from any and all liability for damages, illness, or injury resulting from performing the assistance requested.

Signature of Parent/Guardian: _____ Date:_____

Signature of Nurse: _____ Date: _____