Maple Valley
School District #4
207 Broadway Street, Tower City, ND 58071
www.maple-valley.k12.nd.us

Phone: 701.749.2570 Fax: 701.749.2313

Dan Larson, Superintendent
Michael Nygaard, HS Principal
Courtney Storhoff, K-6 Principal
Cathy Janish, Business Manager

# Authorization/Permission for Administration of OTC Medication

Student Name: _____ Birth Date: _____

Medications and health care procedures required during school which cannot be managed otherwise shall be administered **when the following are on file at the school**:

1. Parent signed, dated authorization/permission given to administer the medication/procedure.
2. Medication/equipment delivered to school by **parent/legal guardian** i**n the original packaging.**
3. Annual renewal of authorization/permission and/or immediate notification, in writing from parent, and change.

Medication/procedure shall be administered by qualified staff and a record maintained. Medication/equipment will be stored in a locked secured area.

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Please administer the following to the above-named student:

Please circle one or both: **Tylenol** **Ibuprofen** **Other:** _____

**AS NEEDED** and/or **Every**_____**Hours**

Route: _____ Dose: _____ Time Given: _____ Discontinue Date: _____

Reason for medication: _____

Possible reaction/side effects: _____

**Parent/Guardian Authorization/Permission**

I request the above pupil be given the medication/procedure while in school and school related activities. I understand the law provides that there shall be no liability for civil damages because of the administration of medication/procedure where the person administering the medication/procedure acts as an ordinarily reasonable, prudent person would under the same similar circumstances. **I agree to pick up the remaining medication or it will be properly destroyed.**

Parent Signature:_____ Date:_____

Address:_____ Cell Phone:_____