PRIOR LAKE-SAVAGE AREA SCHOOLS

Over-The-Counter (OTC) Medication Authorization Form

School Year _____

Student: _____ DOB: _____ Grade _____

DIAGNOSIS/SIGNIFICANT FINDINGS:
HISTORY:
ALLERGIES:

OTC MEDICATIONS REQUIRED DURING SCHOOL HOURS/PROGRAMMING *All authorizations expire at the end of the school year or summer programing*					
Medical Condition	Medication	Dose	Time	Route	Possible Side Effects
1.					
2.					
3.					
4.					

*****Medication must be supplied in the original container and packaging that includes dosing instructions.*****

Parent/Guardian Authorization for Student Self-Administration (Secondary Students Only)

- ☐ My child is knowledgeable about the medication, when to take it, and how much to take.
- ☐ My child knows how to administer the medication.
- ☐ I have read the Self-Administration of Medication Student Agreement (Back of Form)
- ☐ My child may carry/self administer _____ (Please identify) if agreed upon by parent/ guardian and school district. Not applicable for controlled substances or students in elementary or early learning programs.
- ☐ I understand my child is entirely responsible for the use of this medication and use of this medication will not be monitored by school staff.

Date	Parent/Guardian Signature	Relationship to Student	Phone

This Parent/Guardian Authorization for Student Self-Administration does not apply to the possession or use of any drug or product containing ephedrine or pseudoephedrine as its sole active ingredient or as one of its active ingredients.

Parent/Guardian Authorization

1. I request that the OTC medication(s) be given during school hours/programming per dosing instructions on the bottle/box.
2. I give permission for the medication(s) to be given by designated personnel as delegated by the school nurse.
3. Only daily medications and those for life threatening/emergency conditions will be sent on field trips. The administration of medications and delegation may be different when on field trips or at after-hours activities.
4. I release school personnel from liability in the event adverse reactions result from the medication(s).
5. Elementary and early learning students will not be permitted to carry OTC medication into school or self-carry these medications.
6. It is my responsibility to communicate any medication needs or changes to the school district and to programming outside of the school day to programs such as Kid's Company.
7. If my child attends Kid's Company, I give consent for the school district to give this form with my and my child's information to Kid's Company.
8. It is my responsibility to communicate any medication needs or changes to the school district and to programming outside of the school day such as Kid's Company. All programs administering medications for my child will need a separate labeled bottle.

Date	Parent/Guardian Signature	Relationship to Student

PRIOR LAKE-SAVAGE
AREA SCHOOLS

Over-The-Counter (OTC)
Medication Authorization Form

School Year _____

Student: _____ DOB: _____ Grade _____

Self-Administration of Medication Student Agreement

I, _____ agree to:

- Possess and use the medication in a manner consistent with the labeling (e.g., one tablet every 4 hours as needed)
- Use the correct medication administration technique.
- Keep the medication in the original packaging/bottle.
- Maintain a written record of my medication administration at school (form, assignment notebook)
- Not allow anyone else to use my medication.
- Keep a current supply of my medication located: _____.
- I will make sure I have my medication available for field trips or other off-site school events.
- Notify the school nurse or health support of any of the following circumstances:
  _____My symptoms continue or get worse after taking my medication
  _____I suspect that I have side effects from my medication
  _____I have any symptoms of an allergic reaction
  _____I need my medication more frequently than ordered (i.e., one tablet more than every 4 hours).

_____ **Locker # _____ Room # _____**

Signature of Student **Date**

This self-administration of Medication Student Agreement does not apply to the possession or use of any drug or product containing ephedrine or pseudoephedrine as its sole active ingredient or as one of its active ingredients.

The student has demonstrated knowledge about and proper use of his/her medication:

_____

Signature of Health Office Staff **Date**