Owatonna Public Schools
Health Services Office

Over-the-Counter Medication Authorization

Effective December 2, 2002, students in grades 6-12 may be administered non-prescription, over-the-counter medications while at school provided the following guidelines are met.

- Parent or guardian's written authorization is present
- Parents are responsible for providing their students supply of non-prescription medications to be kept in the Health Office
- Medications must be in the original container clearly identifying the medication and recommended dosage
- Dose administered will not exceed the recommended dosage on the labeled container
- Authorization must be renewed yearly

By authorizing administration of over-the-counter medication to my son/daughter during school hours, I release school personnel from any liability in relation to this request when medication is given as directed. I will notify the school health office of any change in the medication (dose change, discontinuation of medication, etc.). I give permission for the school health service office to communicate with school staff about the action and side effects of medication on a need to know basis. I also give permission for the assigned teacher/responsible adult to administer the medication on a field trip, as necessary following school protocol.
****OHS ONLY**: I authorize school staff to send home remaining medication(s) with my son/daughter at the end of the school year unless otherwise indicated.

Student Name :____
First **Last**

Print Parent/Guardian(s) Name: ____ **Date:** ________
First **Last**

Signature authorizing administration of medication: ______________________________ _________

Daytime phone number: ___________________________________

Student Name: ____ **Date of Birth:** ____________
Last **First** **MI**

- **Name of Medication:** _____________________ **Dose:** __________________

  Reason for Medication: ________________________

- **Name of Medication:** _____________________ **Dose:**____________________

  Reason for Medication: _________________________________

- **Name of Medication:** ___________________________________ **Dose:** ________________________

  Reason for Medication: _________________________________

Owatonna Public Schools
Health Services

Student Agreement for Self-Administration of Medication

(to be completed annually)

Please only fill out this page if you would like your student to be able to carry and administer over the counter medications. This privilege can be revoked at any time if students are found to be using the medication inappropriately, sharing medication with another student, or at the professional judgment of the health office nurse.

Student:____ **Date of Birth**:__________________________
Parent(s)/Guardian:____
School:____ **School Year**:___________________________
Name of Medication:____
Order for Use:____ **Lot#** _________ **Exp. Date:** _________

By signing this form, I am requesting the school not administer over the counter medications to my child unless the self carry privilege is revoked.

Parent Signature ___________________________________ Date______________

Student Agreement:

I will responsibly carry the above named medication for self-administration. I will not exceed the dosage recommendations by the physician. I will not share the medication with other students. I understand that the school district may revoke this privilege if it determines that I am abusing the privilege.

____ __________________
Student Signature *Date*

Check List for Nurse to Assure Compliance:	**Date/Nurse Initials**
* Annual written authorization from parent and physician for self-administration	__________________
* Parental request that the school not administer the medication	__________________
* Medication is properly labeled for the student	__________________
* The student has knowledge and skill to safely possess and administer the medication in a school setting	__________________
* Plan for student's safe possession and use of the medication	__________________

In my judgment the above student has adequate knowledge of the use of the above medication and can safely possess the medication in the school setting.

____ ___________________________
Signature of Nurse *Title* *Initials* *Date*