



Fairbanks North Star Borough School District
Over-The-Counter (OTC) Medication Authorization



LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

PERMISSION TO ADMINISTER OTC MEDICATION AT SCHOOL

Medication requests must be deemed necessary to maintain or improve the child’s health and participation in the school program. Over-the-counter (OTC) medications, which are on the approved standing orders from the district medical advisor, may be administered to students when the parent/guardian gives written consent. Each request will be assessed by the nurse for the most appropriate intervention, and the child will be given the standard dosage recommended by the manufacturer.

I consent to the administration of the non-herbal, non-homeopathic over-the-counter medication(s) below. I understand that the school is not legally obligated to administer medication to my child. Employees and agents of the Fairbanks North Star Borough School District (“FNSBSD”) strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless FNSBSD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including for NEGLIGENCE. I agree for Health Services personnel to share health information with FNSBSD staff on a need-to-know basis for my child’s safety and to foster academic success.

I will notify the Health Services team member if I give this medication to my child before arrival at school, while this request is in effect, to prevent over-medicating. I affirm that my child has taken this medicine at least two times in the past without any adverse side effects. **Check all that may be administered by Health Services personnel and/or designated trained unlicensed staff:**

Student has no known drug allergies Student has drug allergies to: _____

OTC medication(s) to be given at school:

<input type="checkbox"/> Tylenol (acetaminophen)	<input type="checkbox"/> Benadryl (diphenhydramine)
<input type="checkbox"/> Motrin/Advil (ibuprofen)	<input type="checkbox"/> TUMS (antacid)

PARENT/GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	PHONE
PARENT/GUARDIAN SIGNATURE		DATE

THIS AUTHORIZATION EXPIRES AT THE END OF THE SCHOOL YEAR AND MUST BE RENEWED EACH FALL

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