



Self-Carry/Self-Administration of Over-the-Counter Pain Medications at School Authorization Form

School: _____ Year: _____

Student Name: _____ Birthdate: _____ Grade: _____

Procedure for students to self-carry and administer **OTC pain relief medications (grades 6-12 Only) at school:**

- The school does not provide the medication
- Medications must be in the original manufacturer's bottle with the label intact. Parents must label the bottle with the student's name
- Signed parental consent is required
- **Over the Counter pain relief medications: Acetaminophen (Tylenol) and/or Nonsteroidal Anti-Inflammatory Drugs (NSAIDS), Ibuprofen or Naproxen only, no combination medication.**
- Parents will direct the student on proper dosage and frequency per label directions
- Permission will be revoked if the school determines that student is abusing the privilege
- No products containing ephedrine or pseudoephedrine as an active ingredient are allowed
- Authorization must be renewed for each school year
- Student must not share medication with any other students
- Student will seek assistance from the Health Office staff if they experience unusual side-effects or do not experience relief as expected from their medication

TO BE COMPLETED BY PARENT/GUARDIAN:

- Medication is permitted in accordance with the district policy and procedure(s). Student's name must appear on the medication container.
- I release school personnel from liability in the event adverse reactions result from taking the medication(s)
- My student requires the following over-the-counter medication:

List Medication names below and reason for taking: ☐ I prefer to have medication(s) kept in the health office

☐ It is my opinion that the above listed student is capable of carrying and self-administering the listed medication(s). I have directed the student on the proper dosage and frequency per label directions.

(Parent/Guardian Printed Name)

(Parent/Guardian Signature)

(Date)

TO BE COMPLETED BY STUDENT:

I agree to:

- Not share medications with any other students
- I release school personnel from liability in the event adverse reactions result from taking the medication(s)
- Notify the Health Office Staff if I am not getting pain relief as expected or are having unusual side-effects after taking my OTC medication

(Student Printed Name)

(Student Signature)

(Date)

TO BE COMPLETED BY HEALTH OFFICE ASSISTANT/DISTRICT NURSE:

- Student can self-carry/self-administer the above listed OTC pain medications

(Health Staff Printed Name)

(Health Staff Signature)

(Date)