ST. JOSEPH
SCHOOL DISTRICT

Authorization for OVER-THE-COUNTER Medications to be taken at School

PARENT SIGNATURE REQUIRED

School _____

Child's Name _____ ____ _____
Last First Sex Date of Birth

_____
Physician's Name Address Telephone Number

- I give permission for the exchange of verbal and written communication between the physician and the school nurse regarding my child's medication regimen.
- I request that my child be assisted in taking the medicine(s) described below at the school by authorized persons or permitted to medicate herself/ himself as also authorized by me and my physician *(see below)*.

☐ **I understand that I, or another designated adult, will need to pick up this medication from the school nurse at the end of this school year. In the event this medication is not picked up, I understand that any remaining medication will be destroyed/ disposed of by the District/ school nurse.**

INIT

_____ _____ _____ _____
Date **PARENT/GUARDIAN SIGNATURE** **Date** **Witness**

NOTE: AGE APPROPRIATE OVER THE COUNTER MEDICATIONS WILL ONLY BE GIVEN ACCORDING TO PACKAGE DIRECTIONS.

Symptom(s) for which medication is given: _____

Name of Medicine: _____

Form: _____ Package Dosing Instructions: _____

_____

Student Age: _____

How soon can it be repeated? _____

Is child authorized to medicate herself/himself? _____

Length of time this treatment is recommended: _____

Other Information:

_____

IF THIS MEDICATION IS USED FREQUENTLY/ OR LONGER THAN 10 DAYS IN A ROW, THE NURSE WILL REQUEST A PHYSICIAN'S ORDER FOR THIS MEDICATION. IF the CHILD CAN SELF MEDICATE WE WILL REQUIRE A PHYSICIAN ORDER.

WE WILL NOT GIVE THIS MEDICATION FIRST THING IN THE MORNING AT SCHOOL WITHOUT DIRECTION FROM A PAREN

Updated 5/31/2024 TSH RN, BSN, NCSN