SAINT THOMAS ACADEMY

AUTHORIZATION FOR SELF-CARRY SELF-ADMINISTRATION OF OTC MEDICATION

STUDENT'S NAME: _____ **BIRTH DATE:** _____ **DATE:** _____

ALLERGIES: _____

GRADE: _____

Procedures For Students In Grades 6-12 To Carry And Use OTC Pain Relief Medication At School:

- The school district does not provide medication.
- Medication must be in the original manufacturer's bottle with the labeling intact.
- Parents will direct student on proper dosage and frequency per label directions.
- Signed parental consent is required.
- 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.
- Students 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 pain relief as expected from their medication.

List medication name(s) below:

_____

_____ _____

PARENT/GUARDIAN PRINTED NAME PARENT/GUARDIAN PRINTED SIGNATURE

PHONE NUMBER #1: _____ PHONE NUMBER #2: _____

COMPLETED BY STUDENT:

I agree to:

- Not share any medications with any other students.
- Notify the Health Office staff if I am not getting pain relief as expected.
- Notify the Health Office staff if I am having unusual side-effects after taking my OTC medication.

STUDENT SIGNATURE: _____ **DATE:** _____

Student may self-carry/self-administer above-listed OTC medication: _____

LICENSED SCHOOL NURSE