

**Maize USD 266
Over-The-Counter Consent Form**



PARENT CONSENT

Name of Student: _____ Date of birth: _____ Grade: _____

FOR STUDENTS IN GRADES 9-12

Drug Name: _____

The student identified above is permitted to carry and self-administer the over-the-counter (OTC) drug(s) listed above. I acknowledge that the school district and its officers, employees or agents incur no liability for damage, injury or death resulting directly or indirectly from the self-administration of OTC medication, and I agree to release, indemnify and hold the district and its officers, employees and agents harmless against any claims relating to the self-administration of the drug by the student identified above. I acknowledge that the student named above may be subject to disciplinary action if found to be giving the drugs to other students.

Parent Signature

Parent (Printed Name)

Today's Date

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CONSENT FOR SCHOOL-PROVIDED OTC DRUGS

List any known allergies or sensitivities that your child has:

School personnel must have signed consent in order to administer these over-the-counter medications. Generic equivalent medications maintained in the health rooms will be used in place of more expensive brand-name items. The school nurse will administer the approved medications as deemed necessary using his/her judgement. Additionally, the school nurse will attempt to contact you upon administration of medication to your son/daughter.

Over-the-counter medications will be administered sparingly when indicated to make your child more comfortable and able to remain at school. For example, the medication may be used for dental pain, mild headaches, orthopedic pain related to recent injury, or in the case of diphenhydramine, symptoms of an acute allergic reaction. You may still need to be contacted for further care of your child. Also, if your child has a fever (100.0 or higher), district policy requires that your child go home from school and not return until fever-free without the use of fever-reducing medication for 24 hours.

Check all desired medication(s) for your child. Dosage will be according to weight.

- ☐ **Acetaminophen (generic for Tylenol®)**
- ☐ **Ibuprofen (generic for Advil®)**
- ☐ **Diphenhydramine (generic for Benadryl®)**
- ☐ **Cetirizine (generic for Zyrtec®)**
- ☐ **Tums® antacid (calcium carbonate)**

I understand that the school employee who administers these medications according to proper dosages shall not be held liable for any adverse reactions to the medication administered. I hereby give my permission for my son/daughter to receive the above medication(s) checked on this form as deemed necessary by the school nurse.

Parent Signature

Parent (Printed Name)

Today's Date