Valdez City Schools
PO Box 398
1112 West Klutina – Valdez, AK 99686
Telephone (907) 835-4357
Fax (907) 835-4964

Non-Prescription (Over the Counter) Medication Authorization

Student Name:_____ DOB:_____
Allergies: _____ Grade:_____

School personnel will assist parents by administering non-prescribed medication to students during the school year. Medication requests must be deemed necessary to maintain or improve the child's health and participation in the school program. 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.**

Parent Consent to Administer Medication

Name of Non-prescription (Over the Counter) medication(s) to be given at school:
_____
Dose: _____ Route:_____ Frequency (PRN?)_____
Reason for medication(s):_____

I consent to the administration of the non-herbal, non-homeopathic over the counter medication(s) listed above. I understand that the school is not legally obligated to administer medication to my child, and in the absence of a school nurse, other school personnel may administer the medication. I agree to defend and hold the school district employees harmless from any liability for the results of the medication or the manner in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements. I will notify the school of any change. I agree to supply medication for my child in its original packaging. I will notify the nurse **if I give this medication to my child before arrival at school, while this request is in effect, to prevent overmedicating. I affirm that my child has taken this medicine at least 2 times in the past without any adverse side effects.**

Name of Parent/Guardian: _____
Signature of Parent/Guardian: _____
Relationship to child:_____ This order is valid only for the current School Year
from start date:_____ to end date:_____

Home Phone: _____ Alternate Phone: _____
*Medication needs to be picked up from the office when discontinued/end of the year or it will be destroyed

Date Picked up:_____ Who Picked Up:_____
Nurse Signature:_____