PERMISSION FOR OVER-THE-COUNTER MEDICATION

ANDERSON SCHOOL DISTRICT 5 SCHOOL HEALTH PROGRAM

TO BE COMPLETED/SIGNED BY PARENT/GUARDIAN

Student's Name: _____ DOB: _____

Name of School: _____ Grade/Teacher: _____

Medication: _____ Dosage: _____

Purpose of Medication: _____ Route: _____

ALLERGIES: _____

Other medications the student is currently taking (prescribed and OTC): _____

Time of day medication is to be given at school: ☐ First dosage to be given at home ☐ PRN (as needed)

____ 8:00 a.m. ____ 10:00 a.m. ____ 12:00 p.m. ____ 2:00 p.m. _____ Other

****Please note: It may be necessary to contact the parent/guardian prior to administering these medications, in order to prevent overmedication and/or possible interaction. _____ Parent/Guardian Initial**

Anticipated number of days medication needs to be given at school:

____ Until the end of the current school year ____ Weeks ____ Days _____ End Date

Special Notes: _____

Special storage requirements: ____ Refrigerate _____ Other

Side Effects: _____

Printed Name, Address, and Phone Number of Health Care Provider: _____

_____

TO BE COMPLETED BY PARENT OR GUARDIAN

I give permission for the school nurse, school principal or his/her designee to administer medication to my child_____ while at school. I will deliver the medication in the properly labeled, manufacturer's container. I give permission for the school principal or the school nurse to contact the health care provider named above to discuss and share information regarding my child's medical condition and/or medication. I am responsible for notifying the school nurse/principal if there are any changes in my child's health condition or plan of care. Any medication not picked up by the last day of school will be destroyed.

Signature of Parent/Guardian: _____ Date: _____