PERMISSION FOR OVER-THE-COUNTER MEDICATION

ANDERSON SCHOOL DISTRICT 5 SCHOOL HEALTH PROGRAM

To be completed by parent/guardian

Student's Name_____ DOB_____

Name of School_____ Teacher's Name_____

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 over-medication and/or possible interaction. _____ initial

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

_____ Until the end of 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 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.

Signature of Parent/Guardian_____ Date_____