In the pursuit of excellence… ..

Caledonia Community Schools

AUTHORIZATION FOR OVER THE COUNTER (OTC) MEDICATION ADMINISTRATION IN SCHOOL

(To be renewed each school year)

Student: _____Date of Birth: _____ Grade: _____ School Year: 21/22

Parent/Guardian: _____Contact Number:_____

School:_____

	MEDICATION	STRENGTH	DOSAGE	HOW IS IT TAKEN	TIME	REASON
(Ex:	ibuprofen	200mg	one tablet	by mouth	every 6 hours As needed	list all that apply)

1. _____

2. _____

3. _____

ADMINISTRATION AGREEMENT

(Please check this section)

_____I request the above named **FDA approved** as needed medication(s) be kept in the school health office and administered to my child during the school day according to the package directions. Only appropriate age based dosages will be administered. Persons who may assist your child with Medications include the school nurse (RN) and trained school staff.

PARENT/GUARDIAN AUTHORIZATION

1. The parent/guardian or other responsible adult must deliver the medication to school with this signed permission form.
2. I understand that the parent/guardian must supply any other OTC medication in the **original container** with the proper label and dosage instructions. Medication must NOT be expired. Medications not meeting the above guidelines will not be administered and will be returned.
3. Field trips – I give permission for daily/emergency medication to be administered on a field trip, as necessary, following school procedure, by trained district staff.
4 .I release all school personnel and any responsible adult administering the medication, from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication(s).
5 .All medications will need to be picked up at the end of the school year by the parent/guardian. Remaining medications will be destroyed.
6. I understand that my written permission must be on file before any OTC medication will be administered.

Parent's/Guardian Signature_____ Date: _____

Reviewed by RN: _____ Date:_____