Authorization/Permission for Administration of <u>OTC Medication</u>

Dakota Valley Public Schools # 61-8 for 2018-19 School Year

Student Name________________________________ Birth Date ___________________

Medications and health care procedures required during school which cannot be managed otherwise shall be administered **when the following are on file at the school:**

1. Parent signed, dated authorization/permission given to administer the medication/procedure.
2. Medication/equipment delivered to school **by the parent** in the **original packaging**
3. Annual renewal of authorization/permission and/or immediate notification, in writing from the parent, and changes.

Medication/procedure shall be administered by qualified staff and a record maintained.
Medication/equipment will be stored in a secure area.

Please administer the following to the above named student:

Please circle one or both ***Tylenol*** ***Ibuprofen*** ***Other*** ________________________________

____
medication

As Needed or every ________hours

____
Route Dose Time given at school Discontinue date/re-eval date

____
Reason for medication/procedure

____
Anticipated reaction/possible side effects

Parent Authorization/Permission

I request the above pupil be given the medication/procedure while in school and school related activities. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication/procedure where the person administering the medication/procedure acts as an ordinarily reasonable, prudent person would under the same similar circumstances. I agree to pick up remaining medication or it will be properly destroyed.

_______________________________________ _______________________________________
Parent Signature Date

____
Parent Address Work Phone Home Phone Cell Phone