

Authorization/Permission for Administration of OTC Medication

Dakota Valley Public Schools # 61-8

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