

# EDEN VALLEY – WATKINS ISD # 463

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## OVER THE COUNTER (OTC) MEDICATION PERMISSION FORM

Students at EVW may have an Over the Counter Medication (OTC) at school for a maximum of 5 days without needing a Doctor's Medical Authorization as long as the following criteria have been met:

- ◇ Parent/guardian must give **written** permission.
- ◇ Medication will only be given as directed (dosage and frequency) on the packaging
- ◇ The product **does NOT contain** any Aspirin, Ephedrine, or Pseudoephedrine.
- ◇ Pain relievers recommended are: Acetaminophen (Tylenol) or Ibuprofen (Motrin, Advil).
- ◇ Medication **MUST** be in the original over-the-counter bottle with a max of 5 doses.
- ◇ The medication is to be kept in the Health Office for safekeeping and administration.
- ◇ The EVW School District reserves the right to revoke this privilege if the above guidelines have not been met or if continued use of the medication is needed.

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade/Homeroom: \_\_\_\_\_

Medication Name: \_\_\_\_\_

Dosage: \_\_\_\_\_ How often: (such as every 4 hours, etc.): \_\_\_\_\_

Is this an "as needed" medication? YES \_\_\_ NO \_\_\_ If no, what doctor is ordering it? : \_\_\_\_\_

Why is this student taking this? (Such as: braces, cough, headache/muscle aches, cramps, etc.)  
\_\_\_\_\_

## PARENTAL REQUEST FOR ADMINISTRATION OF MEDICATION

I agree to follow the above guidelines. I request this over the counter medication to be given as directed on the packaging during school hours and I understand I must provide the medication in the original labeled bottle. I release school staff from liability in the event of reactions resulting from the administration of this medication at school. I authorize the school nurse to release information to and/or obtain information from the health care provider for the purpose of administering and monitoring effects of this medication at school. I also understand that my child's teacher or other designated staff may be consulted in regard to this medication usage to assure my child's safety. I understand that this over the counter medication will not necessarily be administered by the school nurse; alternate staff will have medication administration training.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Day / Cell phone numbers where we may contact you if there are questions or concerns: \_\_\_\_\_

NURSE NOTES: \_\_\_\_\_