EDEN VALLEY – WATKINS ISD # 463

School Nurse (320) 453-2900, ext. 2135
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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: _____