Medication Authorization Form – Non-prescription

Student

STUDENT _____ **GRADE** _____

SCHOOL _____ **BIRTHDATE** _____

ALLERGIES (MEDICATIONS) _____

As parent/guardian of the above named student, I request the School District to give medicine for the following condition(s). This medication request must be deemed necessary to maintain or improve health and participation in the school program. Each request will be assessed for the most appropriate intervention and **will be given at the standard dosage recommended by manufacturer**. ***(Check all that apply***)

CONDITION: **Headache** **Cramps** **Dental** **Other:** _____

MEDICINE: **Acetaminophen** **Ibuprofen** **Naproxen** **Midol/Premsyn/Pamprin** **Other**_____

Dose: _____ **Frequency:** _____**(if less than manufacturer's recommended dose)**
Specify Time: _____ **or As Needed:** _____**Side Effects**_____
Special Instructions for Administration_____

I understand that the school is not legally obligated to administer medication to my child. Therefore, I agree to defend and hold harmless, the school district and its employees from any liability for the results of the medication or the manner in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements. I understand that in the absence of the school nurse, other trained school staff will administer the medication**. I will notify the nurse if I give this medication to my child before arrival at school while this request is in effect to prevent overmedicating. I also affirm that my child has taken this medicine at least two times in the past without any adverse side effects.** I agree to supply medication for my student in its original packaging (small bottles only, please). I understand that the medicine will be destroyed unless picked up by the end of the last student school day of this year. Medicines will not be kept by the school over the summer break per DEA regulations.
Parent/Legal Guardian Signature: _____ **Printed Parent Name:** _____
Date: _____

OVER THE COUNTER MEDICATION ADMINISTRATION RECORD

DATE~TIME~MED~INITIALS	DATE~TIME~MED~INITIALS	DATE~TIME~MED~INITIALS	DATE~TIME~MED~INITIALS

Initials_____ **Name** _____ **Initials**_____ **Name** _____

Initials_____ **Name** _____ **Initials**_____ **Name** _____

School Nurse Signature_____***Date***_____
Phone _____ **Fax** _____**Email** _____

Adapted from Anchorage School District form 8-2012, revised 9-2013