

Non-Prescription (OTC) Medication

Permission for School Administration

Please note the following:

1. Medication should be administered by a parent/guardian before or after school, when possible.
2. Medication must be brought to school by a responsible adult. **(Do not send medication in with a child.)**
3. Non-Prescription also known as **Over the Counter (OTC)** medications must be delivered to the school nurse in the **unopened, original container with manufacturer's label.**
4. Due to limited storage space, please do not bring large quantities of OTC medications
5. **Over the Counter (OTC)** medications may only be given within the limits and according to the instructions printed on the manufacturer's container or the package insert. If the OTC medication is to be dispensed outside of the recommended manufacturer's guidelines, then a Physician's order will be required. Also, if the OTC medication is to be given longer than recommended guidelines a Physician's order will be required.
6. Herbal substances are not considered medication and will not be administered by the school nurse.
7. First doses of a medication that a child has never received will not be given at school.
8. HCS district may reject requests for certain medications to be given at school.
9. This form remains in effect if the child transfers to another school within HCS district for the current school year.
10. You **MUST** complete a **separate form for each medication** that is to be given at school.
11. If the medication is to be given to more than one of your children, you **MUST** complete a **separate form for each child.**

Child's Full Name: _____ **Grade Level:** _____

Date of Birth: _____ **Gender:** Male or Female

| | |
|---|---|
| Name of (OTC) Non-Prescription Medication to be given: | Reason(s) for this Medication to be given at school: |
| Dose / Amount: (must be according to the manufacturer's instructions) | Frequency: (must be within the limits of the manufacturer's instructions) |
| Number of days this medication will be given at school: <input type="checkbox"/> until the end of the current school year <input type="checkbox"/> _____ days | Special Storage Requirements: <input type="checkbox"/> No <input type="checkbox"/> Yes: _____ |

Does this child have **any known allergies?** No Yes
 (If yes, list all known allergies and type of reaction(s): _____)

Does this child **take any additional medications at home or at school?** No Yes
 (If yes, list the medications taken at home): _____

Child's Health Care Provider's Name & Office: _____ **Phone:** _____

- I understand and agree with all the following:**
- I give permission for my child to be given the above medication while at school per HCS district's policies.
 - I give permission for information about this medication and/or my child's health to be exchanged between the HCS school nurse or designated HCS employee and/or my child's Health Care Provider.
 - I further give permission for information about my child to be shared with persons who legitimately need to know for the safety and well-being of my child.
 - I agree to follow the HCS district policies concerning medications.
 - I agree I am responsible for providing the school with the medication for my child and any supplies needed.
 - I agree that I am responsible for notifying the school if my child's health and/or medication(s) change in any way.

Parent/Guardian's Signature Parent/Guardian's Name (Print) Date Phone Number

**Please note that this form is only valid if signed and dated on or after July 1 for the upcoming school year.*