

Mineral County Schools

Permission for Medication – Over the Counter

Parents/guardians complete *Student/Medication Information* and *Consent* sections.

School Staff complete *School Section*.

Student/Medication Information

Name of Student: _____ Date of Birth: _____

Medication allergies: No Yes, list known allergies _____

School: _____ Grade: _____

Medication: _____ Dosage : _____

Purpose of Medication: _____

Duration: Permission for medication to be continued until end of school year unless otherwise noted: _____

Consent

- I give my permission for the above named student to take the above medication at school as indicated.
- I understand that the medication will be given to my child by a school nurse or a school staff member.
- I will bring the medication to school myself or by another responsible adult. Students are not allowed to carry medication unless allowed to do so by law or specific school plan.
- The medication must be brought to school in the original container with label intact.
- The medication cannot be past the expiration date listed on the bottle.
- I certify that my child has had at least one dose of the medication and has shown no apparent reaction to it.
- Medications will be administered as needed in dosages indicated by the manufacturer. Any requests to administer dosages outside of manufacturer instructions will require a physician order.
- Unused medication will be discarded at the end of the school year or sooner if indicated.

Date

Parent or Guardian Signature

School Section

- I verify that I received the above listed medication from the parent or a responsible adult.
- Medications will be administered as needed in dosages indicated by the manufacturer. Any requests to administer dosages outside of manufacturer instructions will require a physician order.
- Please indicate how many doses were received from the adult: _____

Date

School Personnel Signature

