Santa Fe Trail USD #434

Over The Counter Medication Permission Form

STUDENT NAME:
(one student per form)

Date of Birth:

Grade:

PRN Medication Supplied by Student/Parent: YES NO

Medication: ***TYLENOL, IBUPROEN, ANTICAIDS, COUGH DROPS, ANTIHISTAMINES, HYDROCORTISONE CREAM, ANTIBIOTIC/ANTIFUNGAL OINTMENT***

Dose: ***PER LABEL INSTRUCTIONS***

Time of Administration: ***PER LABEL INSTRUCTIONS***

Reason for Medication/Diagnosis: ***PER LABEL INSTRUCTIONS***

Any known drug allergies:

I hereby give my permission for the student named above to take the above listed medication at school as ordered. I understand that it is my responsibility to furnish this medication in the original bottle to the school health office where it will be kept while school is in session. I further understand that any school employee who administers any drug or nonprescription medication pursuant to parental written request to my student in accordance with written instruction from the physician or dentist shall not be liable for damages as a result of an adverse medication reaction suffered by the student because of administration of such medication.

NOTE: This medication is to be brought to school in the original container appropriately labeled by the pharmacy, or physician, stating the patient's named, the name of the medication, the dosage and times it is to be administered.

Parent/Guardian Name: Date:

Parent/Guardian Signature:

For Health Office Use Only

Form Received/Reviewed by District Nurse
Name/Date:

Medication Check In

Date	Quantity	

Updated 1/2023