Yuma School District #1

OVER THE COUNTER (OTC) MEDICATION ADMINISTRATION/ PARENT AUTHORIZATION

School Year:_____-_____

STUDENT INFORMATION

Student's Name: _____ **School:** _____

Date of Birth: ____/____/_____ Age: _____ Weight:_____pounds Grade: _____ Teacher: _____

▢ **No known drug allergies**

▢ **Yes, drug allergies, list:**_____

▢ **Other significant allergies (nuts, bees, latex, etc):** _____

OVER THE COUNTER MEDICATION AUTHORIZATION (To be completed by parent)

Medication Name: _____

Reason for taking medication:_____

Dosage:_____ **Circle One:** Liquid / pill / capsule / dissolvable

Frequency/Time(s) to be given as needed:_____

Start Date: ___/___/___ **Stop Date:** ___/___/___

PARENT AUTHORIZATION

I authorize and delegate the school registered nurse (RN) to administer and/or train the unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent signed statements will be necessary if the dosage of medication is changed.

This medication will only be given "as needed" for the reason stated on this form. If the medication needs to be administered frequently or for more than 3 consecutive days, parents/guardians will be contacted to seek guidance from their medical provider. At that time, medication will be placed on hold.

Over the Counter Medication must be brought to the school health office in the original, unopened and sealed container in order to follow YSD1 over the counter medication policy.

Parent's/Guardian's Signature:_____**Date:**____/___/____ **Phone: (____)_____-_____**

RN Signature_____ Date:_____

HA Signature_____ Date:_____

Date received: _____Qty:_____ Parent Sign:_____RN/HA:_____

Date received: _____Qty:_____ Parent Sign:_____RN/HA:_____

Date **Returned**:_____Qty:_____ Parent Sign:_____RN/HA:_____

Revised 2023