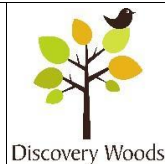


AUTHORIZATION FOR ADMINISTRATION OF NON-PRESCRIPTION/OVER-THE COUNTER MEDICATION (OTC)



604 N 7th Street
Brainerd, MN 56401
218-828-8200
office@discoverywoods.com

THIS FORM IS VOID IF ALTERED IN ANY WAY

INSTRUCTIONS: Each of the three sections must be completed by parent/guardian for student to receive an over-the-counter (OTC), medication below. **Parents will be notified when student receives an OTC medication.**

I. STUDENT INFORMATION (To Be Completed By Parent/Guardian).

Student's Name (Last, First, Middle)	Birth Date	Grade	Medication Allergy
Parent/Guardian		Address	
Cell/Home Phone		Work Phone	

II. ACTION PLAN (To Be Completed By Parent/Guardian). Please complete all spaces. Check yes or no to indicate which of the approved list of over-the-counter medications may be administered when indicated by student's symptoms.

THIS REQUEST IS TO BE EFFECTIVE FOR THE 2019-20 SCHOOL YEAR OR EARLIER STOP DATE: _____

Over-the-Counter Medication	Dosage and Time	Condition/Symptoms	Possible Side-Effects*	Comments
Acetaminophen (Tylenol ®) *Must be provided by parent <input type="checkbox"/> Yes <input type="checkbox"/> No	Administer according to the manufacturer's label	For relief of minor aches & pain; fever (100.0°) will not be treated at school unless nursing assessment indicated need for treatment of 102° or higher temperature while awaiting transportation home	None significant if administered per manufacturer's label	Alert: Students with temperature of 100.0° must be sent home and are not able to return for 24 hours after fever breaks.
Calcium Carbonate (Tums ®) *Must be provided by parent <input type="checkbox"/> Yes <input type="checkbox"/> No	Administer according to the manufacturer's label	For stomach ache or heart burn	Constipation	Not to be used in children less than 6 years old
Diphenhydramine (Benadryl ®) *Must be provided by parent <input type="checkbox"/> Yes <input type="checkbox"/> No	Administer according to the manufacturer's label	For allergy symptoms	Drowsiness or excitability	
Ibuprofen (Advil ®, Motrin ®) *Must be provided by parent <input type="checkbox"/> Yes <input type="checkbox"/> No	Administer according to the manufacturer's label	For temporary relief of pain and itching caused by insect bites and stings	Stomach upset	Alert: Contains no aspirin (salicylates), but should not be given if student has allergy to aspirin; may cause stomach bleeding. Students with temperature of 100.0° must be sent home and are not able to return for 24 hours after fever breaks.

***Manufacturer's label is maintained in school office for parents to review upon request.**

Please see back to sign consent.

III.PARENTAL PERMISSION (To Be Completed By Parent/Guardian). Form is void if this section is incomplete.

I request the designated school personnel to assist my child in the administration of the above described medication/s. I give permission for my child to take the medication indicated above by checking the yes box according to the condition/symptoms described while in school or while participating in school activities away from the school. I understand that (1) there is not liability on the part of the school district, or its personnel, for civil damages as a result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonable prudent person would have acted under the same or similar circumstances; (2) I will be notified of the medication and time that the OTC medication was administered to my child; (3) I will be contacted if my child's symptoms do not improve and s/he is unable to remain at school.

Parent/Guardian Signature: _____ Date: _____

Students are not allowed to bring or carry any over-the-counter medications to school or school sponsored activities. All over-the-counter medications must be dropped off to office by parents/guardians.