

Authorization for Administration of OTC Medication at School

TO BE COMPLETED BY PARENT/GUARDIAN

Student Name: _____ D.O.B. _____

School: _____ Grade: Level _____

<u>NAME OF MEDICATION</u>	<u>DOSAGE</u>	<u>ROUTE</u>	<u>REASON TO BE GIVEN</u>
#1 _____	_____	_____	_____
#2 _____	_____	_____	_____
#3 _____	_____	_____	_____
#4 _____	_____	_____	_____

PLEASE NOTE: OVER-THE-COUNTER MEDICATIONS WILL BE GIVEN ONLY FOR REASONS STATED, SO PLEASE LIST ALL REASONS TO GIVE MEDICATION.

Medications **will not be given** in larger doses more often than directed by manufacturer without a doctor's note.

Possible side effects of medication:

- #1 _____
- #2 _____
- #3 _____
- #4 _____

Parent/guardian/caretaker will provide all over-the-counter medications in the original containers.
District #145 does not provide over-the-counter medications for students use.

I request/authorize SCHOOL DISTRICT 145 to give medication to my student in accordance with the instructions written above, from this date forward until the end of the current year unless otherwise notified. I understand that trained unlicensed staff may be assigned to provide medication to my student, and I accept ultimate responsibility for monitoring the effects of this medication.

Date _____ Parent/Guardian Signature _____

Home Phone _____

Work Phone _____

Cell Phone _____

*This form must be on file in the nurse's office before any OTC medication will be given to your child.

Authorization for Administration of Prescription Medication or inhaler at School

TO BE COMPLETED BY PARENT/GUARDIAN

I request/authorize the school to give medication to my student in accordance with the instructions written below. I understand that unlicensed staff may be assigned to provide medication to my student, and I accept ultimate responsibility for monitoring the effects of this medication.

Student Name: _____ D.O.B. _____

School: _____ Grade: Level _____

<u>NAME OF MEDICATION</u>	<u>DOSAGE</u>	<u>ROUTE</u>	<u>REASON TO BE GIVEN</u>
#1 _____	_____	_____	_____
#2 _____	_____	_____	_____

If given as needed, specify the length of time between doses: _____

Possible side effects of medication: _____

Emergency procedure in case of serious side effects: _____

Permission to carry inhaler on person _____ Yes _____ No

I request and authorize that the above named student be administered/provided the above identified medication in accordance with the instructions indicated above from _____ to _____

(not to exceed the current school year).

Parent/guardian will provide all prescription medications in the original containers.

Date _____ Parent/Guardian Signature _____

Home Phone _____ Work Phone _____

Cell Phone _____

*This form ***must*** accompany any prescription medication to be given at school. No medication can be given to your child without it. .

Dental Health Information

For the current School Year

Parents:

Please fill in the information regarding your student’s dental health care and return to school no later than **August 31, of the current School Year**. If the form is not returned your student must, according to state regulations, be examined during the dental screening later this year. Either you and /or your child’s dentist may fill out the form.

Thank you for your prompt attention to our child’s health needs.

Sincerely,

Lanel Fenster, RN, BSN
School Nurse

Dental Waiver Form

Return by August 31, of the current School Year

Student’s Name: _____ Grade: _____

_____ This student **has** been examined by a dentist at least one time during the last calendar year. Date of last dental visit _____.

_____ This student **has NOT** been examined by a dentist at least one time during the last calendar year. I do not wish my child to be screened at this time.

_____ Date: _____
Parent Signature

_____ Date: _____
Dentist Signature (Optional)