AUTHORIZATION/PARENTAL CONSENT FOR ADMINISTERING OVER-THE-COUNTER MEDICATION

All Ballard County schools must have the parent/guardian's authorization for a nurse to administer over-the-counter medications or, in his/her absence, the principal and/or designated staff to administer these medications. Medications must be in their original containers and include label information about the name of drug, strength, dosage and frequency. The student's name also should be on the container. Please complete both the front and back of this form. To view the district's policy on medication administration, please contact Bob Wilson at 665-8400, ext. 2014, or ask the school nurse.

Student's name: _____ Birth date: _____

Grade: _____ Teacher: _____

Allergies: _____

_____

Reason student is receiving medication:

_____

Name of medication: Dosage: Date to DC:

_____

Possible reactions: _____

Form of medication: Tablet _____ Pill _____ Capsule _____ Liquid _____ Inhalant _____ Other: _____

Feedback required: Yes _____ No _____ If yes, frequency of feedback: _____

To be completed by parent or guardian:

I give permission for _____ to receive the above over-the-counter medication at school according to standard school policy. I understand that I have the ultimate responsibility for providing the school with an adequate supply of this medication. I understand that ALL medication must be delivered to the school by a parent/guardian, either to the main office or school nurse's office**. All medication must be in its original container with the correct name, medication, dosage and frequency of use.** I hereby release Ballard County Schools and its employees from any claims or liability connected with its reliance on this permission form, and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I am responsible to notify the school in writing of any changes made regarding my child's medication or medical needs, and to pick up any unused medication at the end of the school year.

X _____ _____
Parent/Guardian signature Date

Daytime phone:_____ Cell phone:_____

2015-16 STUDENT MEDICATION LOG

Name_____ Parent_____ Home/Cell/Work_____

Physician _____ Phone _____ Allergies _____

Medication_____ Route _____ Dosage _____ Time to be given _____

Discontinued medication _____ Parent/Guardian notified to pick-up meds _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
Sept																															
Oct																															
Nov																															
Dec																															
Jan																															
Feb																															
Mar																															
April																															
May																															

Subs: Name _____ Initials _____
Name _____ Initials _____
Name _____ Initials _____
Name _____ Initials _____
Name _____ Initials _____

CODES:

A = Absent D = Early dismissal
N = None available F = Field trip
W = Dose withheld X = No school
O = No-show