OVER THE COUNTER MEDICATION CONSENT FORM 12-13

PINE CITY SCHOOLS HEALTH SERVICES

_____ _____

(Name of student) (Grade/Teacher)

The Pine City School District Staff has my permission to administer the following in the dosage and timeframe recommended on the medication package to my child

_____ For the following symptoms:_____

(name of medication)

PCHS-JR/SR HIGH STUDENTS ONLY:
Students may self administer over the counter **PAIN RELIVERS ONLY** (tylenol or ibuprofen)

My student may self administer/self carry this medication. Initial here to indicate consent :_____

I understand and agree to the following:

1. **All medication must be provided in the original container**. Medication sent to school in baggies, envelopes or other containers will not be administered and will be returned home with the student.
2. A written statement will be submitted to the School Nurse when the medication is to be discontinued.
3. All medications given by school staff must be approved by the FDA.
4. **All medication must state it is approved for use in children**. If a medication is not approved for use in children, it may be administered with a physician's order. Please ask your physician to provide the school with written orders to administer this medication to your child.
5. This permission is no longer valid at the end of the school year and medication will be disposed of at this time if arrangements are not made by the parent to pick up remaining medication.

Signature of Parent/Guardian:_____Date: _____

For Office Use Only:

_____original container approved for use in children_____ FDA approved_____

_____parent permission amount received_____ Expiration Date: _____

_____Self Carry expectations discussed w/ student by nurse :_____date: _____

medication contains:_____

Strength:_____ LSN NOTIFED (date & time):_____

If you have questions about this form or the school medication policy, please contact Glenda Christianson, School Nurse at (320) 629-4214 (Elementary School) or (320) 629-4116 (JR/SR High)
email:gchristianson@pinecity.k12.mn.us

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Student Name: _____ Grade/Teacher: _____

Name of medication: _____ Dose Supplied: _____mg

Dosage to be given: LUNCHTIME @ _____ OR EVERY _____ HOURS PRN or DAILY

Route: _____ ALLERGIES:_____

Reason: pain cough headache stomachache/reflux Other:_____

12-13	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY	12-13
1	NS			NS	NS					1
2	NS			NS		NS	NS			2
3	NS		NS			NS	NS			3
4			NS						NS	4
5			NS		NS				NS	5
6		NS			NS			NS		6
7		NS						NS		7
8	NS			NS						8
9	NS			NS		NS	NS			9
10			NS			NS	NS			10
11			NS						NS	11
12					NS				NS	12
13		NS			NS			NS		13
14		NS						NS		14
15	NS			NS						15
16	NS		NS	NS		NS	NS			16
17			NS			NS	NS			17
18		NS	NS			NS			NS	18
19		NS			NS				NS	19
20		NS			NS			NS		20
21		NS			NS			NS		21
22	NS		NS	NS						22
23	NS		NS	NS		NS	NS			23
24			NS	NS		NS	NS			24
25			NS	NS			NS		NS	25
26				NS	NS		NS		NS	26
27		NS		NS	NS		NS	NS	NS	27
28		NS		NS			NS	NS		28
29	NS			NS		-------	NS			29
30	NS			NS		-------	NS			30
31	------		-------	NS		-------	NS	-------		31

Signature	Initials	Signature	Initials

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PINE CITY SCHOOLS HEALTH SERVICES

KEY: NS=No School A=absent *=see narrative notes Initials=completed w/o difficulty