School District of River Falls

OVER-THE-COUNTER (OTC) MEDICATION AUTHORIZATION

Student Name: _____ Birthdate: _____

Grade: _____ School: _____ Effective School Year: _____

As the parent/guardian of the above mentioned student, I give the River Falls School District permission to administer the following medication(s) to my child. The administration of FDA approved non-prescription medication (OTC) requires written instruction and consent of the student's parent/guardian. All non-prescription medications (OTC) must arrive at school in the original, **unopened, manufacturer's package**, complete with package ingredients and recommended dose in a legible format. All non-prescription medication (OTC) will be given according to package directions. Health Office staff cannot administer expired medication or medication that is not received in its original manufacturer's package.

Medication	Dosage, Route, and Time	Reason OTC given to your child:	Considerations:
○ Acetaminophen (Tylenol)	○ Administer per manufactures label Other Specify _____	Specify:_____ _____	**Alert**: Student with temperature over 100.0 will be sent home
○ Diphenhydramine (Benadryl)	○ Administer per manufactures label Other Specify_____	Specify:_____ _____	Specify:_____ _____
○ Ibuprofen (Advil, Motrin)	○ Administer per manufactures label Other Specify_____	Specify:_____ _____	Specify:_____ _____
○ Cough Drops (Halls, Ricola, Luden)	Drops per day _____	Specify:_____ _____	Specify:_____ _____
○ _____	○ Administer per manufactures label Other Specify_____	Specify:_____ _____	Specify:_____ _____
○ _____	○ Administer per manufactures label Other Specify_____	Specify:_____ _____	Specify:_____ _____

As the parent/guardian of the above mentioned student, I will keep the school district aware of any changes in medication(s), profile or health concerns of my child. I give my medical provider and River Falls School District permission to release and obtain information from each other as necessary to administer medication. I understand that the medication will be disposed of on the last day of school.

Child's Physician: _____ Clinic Location: _____

Clinic Address: _____ Clinic Phone: _____

Parent/Guardian Signature: _____ **Date:** _____

"Practitioner" means any physician, dentist, optometrist, physician assistant, advanced practice nurse prescriber, or podiatrist licensed in any state.

12/2015