PARENT AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION
OR
SHORT TERM PRESCRIPTION MEDICATION (taken less than 14 days)

Student's Name____ ID#________________________________

Date of Birth____________ School______________________________ School Year_________________

Name of medication___________________________________ Dosage___________________________

Time of administration____

Special instructions/reason for medication: ____

Please list any medication or food allergies:____

Will the student be carrying and taking this medication on his/her own? □Yes □No
Students are not allowed to carry controlled substances (for example, Tylenol #3) and will be required to come to the Health Office to take any medication classified as a controlled substance.

If YES is selected: I/We understand that our child will be responsible for carrying and taking his/her own medication and that he/she is only authorized to carry one day's supply of medication in the ORIGINAL LABELED container indicating the name of the medication and the dose of the medication or dosing recommendations.

A student requiring OTC medication more than 3 times/month or more than 3 consecutive days should be considered for a medical evaluation. Please note that if our school nurse is not physically present to administer your child's medication (prescription or over the counter), our School Health Assistant or Administrative Assistant will do so in place of the Nurse. This form will serve as consent for the duration of the 2015-2016 academic year. Please contact our Nurse at (575) 751-7222 ext 219 if you have any additional questions or concerns regarding this medication administration consent. You may return this form to the front office or to the Nurse's office. Thank you.

Parent/Guardian Signature: _____________________________________Date: _______________________

Phone #(s): ____

School Nurse Signature: ____ Date: ______________________

Date _______________ medication brought for storage in the Health Office. **Expiration date**: ___________
Amount of medication ________________________________ (two adults count medication and record)

____ _______________________________________
Signature of person counting Signature of person counting

End of Year Instruction:
□ I will pick up unused medication on the last day of school (medication will be discarded if I do not pick it up by the end of the day)
□ Please discard unused medication on the last day of school
Date: ____________medication □ returned □destroyed at end of school year.

______________________________________ ___________________________________
Signature of person returning/discarding med Signature of person picking up/discarding med

OTC/SHORT TERM PRESCRIPTION INDIVIDUAL MEDICATION LOG

Student's Name____ ID#_______________________

Date of Birth_____________ School_____________________________ School Year_____________

Name of medication: ___________________________________ Dosage: __________________________

Time of administration/instructions: ____

____ ____
Nurse signature and initials Nurse signature and initials

____ ____
Health assistant and initials Staff signature and initials

____ ____
Staff signature and initials Staff signature and initials

DATE	TIME	INITIALS	PARENT NOTIFIED	DATE	TIME	INITIALS	PARENT NOTIFIED