HAYWOOD COUNTY SCHOOLS

AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION AT SCHOOL

STUDENT'S NAME _____ **BIRTHDATE** _____

DATE _____ **SCHOOL** _____ TEACHER _____ GRADE _____

DOCTOR'S NAME _____ **DOCTOR'S PHONE NUMBER** _____

MEDICATION _____ **STRENGTH** _____
(EXAMPLE: 25MG PER PILL)

DOSAGE _____
(AMOUNT TO BE GIVEN)

ROUTE OF ADMINISTRATION _____
[EXAMPLE: BY MOUTH, INHALED (INHALER), OR TOPICAL (APPLY TO SKIN)]

REASONS TO GIVE MEDICATION _____
(EXAMPLES: HEADACHE, STOMACHACHE, TOOTHACHE, ITCHING, GENERAL ACHES, PAIN OR FEVER)

****PLEASE LIST ALL REASONS. (WE CANNOT GIVE MEDICINE FOR ANY REASON OTHER THAN WHAT YOU LIST ABOVE.)****

TIME TO GIVE MEDICATION OR HOW OFTEN TO GIVE _____ AM OR PM
(EXAMPLE: 2 PM OR EVERY 4-6 HOURS AS NEEDED)

LENGTH OF TIME TO GIVE THIS MEDICATION _____
(EXAMPLE: ONE TIME, 2 WEEKS, OR AS NEEDED ALL SCHOOL YEAR)

EFFECTS THIS MEDICATION HAS ON YOUR CHILD _____
(EXAMPLE: SLEEPY, SHAKY, OR NO PROBLEM AT ALL)

OVER-THE-COUNTER MEDICATIONS CAN BE ACCEPTED IF:

IN ORIGINAL BOX OR CONTAINER WITH ORIGINAL LABEL.

(PARENTS / GUARDIAN PLEASE BRING MEDICATION TO THE SCHOOL. FOR YOUR CHILD'S SAFETY AND OTHERS' PLEASE DO NOT SEND IN BOOK BAG OR ON BUS.)

**** COUGH DROPS ARE A KNOWN CHOKING HAZARD FOR YOUR CHILD. ****
THEREFORE, WE DISCOURAGE THE USE OF COUGH DROPS.

PARENT'S PERMISSION

I HEREBY GIVE MY PERMISSION FOR MY CHILD (NAMED ABOVE) TO RECEIVE MEDICATION DURING SCHOOL HOURS. I UNDERSTAND THE SCHOOL UNDERTAKES NO RESPONSIBILITY FOR THE ADMINISTRATION OF THE MEDICATION. I HEREBY RELEASE THE HAYWOOD COUNTY BOARD OF EDUCATION AND THEIR AGENTS AND EMPLOYEES FROM ANY AND ALL LIABILITY THAT MAY RESULT FROM MY CHILD TAKING THE OVER THE COUNTER MEDICATION. I AGREE TO NOTIFY THE SCHOOL OF ANY CHANGE.

PARENT/GUARDIAN SIGNATURE _____ **CONTACT NUMBER** _____

EVIEWED BY _____ SCHOOL NURSE Date _____

MEDICATION ADMINISTRATION LOG

STUDENT NAME: _____ **TEACHER:** _____ **GRADE:** _____

SCHOOL: _____ SCHOOL YEAR: _____

MEDICATION: _____ ROUTE: By mouth Injected Inhaled Topical Rectum (CIRCLE ONE)

DOSE: _____ TIME TO GIVE: _____

(STRENGTH AND AMOUNT TO GIVE) **(WITH IN + OR - 30 MINUTES)**

Reason for giving medication: _____

******PLEASE USE THE FOLLOWING CODES TO DOCUMENT THE REASON MEDICATION WAS NOT GIVEN OR OMITTED******

ED = EARLY DISMISSAL **DC** = DISCONTINUED AT PARENTS REQUEST/DR. REQUEST **R** = REFUSED **AB** = ABSENT **FT** = FIELD TRIP **NMS** = NO MEDICATION AT SCHOOL NS = NO SCHOOL
RX=PRESCRIPTION B=EMPTY BOTTLE SENDT HOME N=NOTE SENT HOME/LOW ON MEDS

******REASON FOR GIVING MUST MATCH REASON LISTED ON PERMISSION FORM******

DATE	TIME	DOSE	REASON GIVEN OR NOT GIVEN	INITIALS	DATE	TIME	DOSE	REASON GIVEN OR NOT GIVEN	INITIALS

ADMINISTERED BY: _____ _____ _____

INITIALS / SIGNATURE INITIALS / SIGNATURE INITIALS / SIGNATURE

ev. HCHD 2013