Over the Counter (OTC) Medication Authorization

West Carrollton Middle School or High School

Complete IF you want your child to receive OTC ibuprofen "Advil/Motrin" or acetaminophen "Tylenol"

Name of Student: _____ Date: _____

Birth date: _____ School: _____ Grade: _____

Ohio law (ORC 3313.713) states school personnel are not legally obligated to administer medication. West Carrollton School District has adopted a policy whereby authorized **specific** school personnel may administer medications under the following conditions.

1. **The medication cannot be scheduled for other than school hours.**
2. Submission of completed OTC medication authorization form with parent/guardian signature.
3. West Carrollton Middle School and West Carrollton High School will provide stock bottles of ibuprofen ("Advil/Motrin") and acetaminophen ("Tylenol").
4. Other than ibuprofen and acetaminophen, all over the counter medications must be brought to the clinic by the parent in the original container.
5. All requests for over the counter medications must receive school nurse approval.
6. All medications will be stored in the clinic and discarded at the end of the year if not picked up.
7. Contact with parent/guardian may be necessary before administering medication.

I request designated school personnel to administer the over the counter medication(s) I have authorized, as written below. I certify that I have legal authority to consent to medical treatment for the student. I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable and unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Name of medication: Acetaminophen

How much to give: 1-2 tablets

How often: Every 4-6 hours, as needed

Give it for: Minor aches & pains

Date: _____

Signature: _____
Parent/Guardian

Name of medication: Ibuprofen

How much to give: 1-2 tablets

How often: Every 4-6 hours, as needed

Give it for: Minor aches & pains

Date: _____

Signature: _____
Parent/Guardian

Home #: _____ Cell #: _____ Work #: _____

Review by WCSD School Nurse:
School Nurse Signature: _____

Date: _____

Comments:

Jan. 2009
WCSD Nursing Services