iLearn Health Office

OVER-THE-COUNTER (OTC) Medication Authorization

Student's name _____ Grade: _____

Date of Birth: _____ Allergies: _____

PARENT/GUARDIAN PERMISSION:

I request that the school nurse at iLearn Charter School assist my child in taking the over-the-counter medication(s) as indicated below.

I shall hold harmless and indemnify iLearn Charter Schools and its agents, employees, and board members against all claims, judgments, or liability arising out of administering said over-the-counter medication(s) to my child.

I, or a responsible adult, will be responsible for bringing the over-the-counter medications to the school in the original sealed manufacturer's container.

I also understand that I am responsible for maintaining enough of the medication at the school. Failure to do this will result in an interruption and discontinuation of the school's administration of the OTC medication for my child.

School personnel have permission to communicate with my child's Pediatrician if any side effects, ill-response, and /or any contraindications to the said medication(s).

☐ I confirm that my child has previously taken this medication.

☐ My child has not previously taken this medication, but this is an emergency medication.

_____ _____ ____/_____/_____

Signature of Parent/Legal Guardian Relationship Date:

I ,_____, am authorizing the following OVER-THE-COUNTER medication(s) for my child

_____(child's first and last name) to be administered at iLearn Charter Schools BY THE SCHOOL NURSE.

OVER- THE -COUNTER MEDICATION (S)

DAILY

Name of Daily Medication (Generic and Trade Name)	REASON	DOSE (mg, mcg)	ROUTE BY MOUTH	Frequency	Time(s) (AM/PM)	Possible Adverse Side Effect or Contraindications	notes

PRN (AS NEEDED)

Name of Daily Medication (Generic and Trade Name)	REASON	DOSE (mg, mcg)	ROUTE BY MOUTH	Frequency	Time(s) (AM/PM)	Possible Adverse Side Effect or Contraindications	NOTE

DATE:____ /_____/_____

_____ _____

PARENT PRINTED NAME PARENT SIGNATURE