CENTRAL SPRINGS COMMUNITY SCHOOL DISTRICT
PARENTAL PERMISSION FOR ADMINISTERING
***Over The Counter* MEDICATION AT SCHOOL**

Student name:_____Grade:_____Date:_____

Please check the approved over the counter medications that can be given to student:

_____ACETAMINOPHEN

_____IBUPROFEN

_____ANTI-ITCH CREAM (e.g. hydrocortisone, Callergy Clear)

_____VASELINE

_____SALINE DROPS

_____Cough Drops

_____TUMS/Antacid

_____Triple Antibiotic Ointment/Bacitracin Ointment

NOTE: The school has limited OTC medications. Parents should provide over the counter medications for their students. See Medication Administration Policy for more details.

I request that a qualified staff person administer the above medication according to the package directions. I agree that medication information may be shared with school personnel who need to know. I understand the law provides that there shall be no liability for damages as a result of the administration of medication when the person administering the medication acts as an ordinary, reasonable, prudent person, who would act under the same circumstances. The school district and the school nurse are to incur no liability, except for gross negligence, as a result of injury arising from the administration of medication.

Parent/Guardian name_____
*Signature_____
Date Home Phone_____
Work Phone_____

MEDICATION WILL NOT BE GIVEN IF IT HAS EXPIRED OR IT HAS AN IMPROPER LABEL.PLEASE CHECK THE CONTAINER BEFORE SENDING IT TO SCHOOL.

PERMISSION FOR DISPOSAL OF UNUSED MEDICATION AT THE END OF THE SCHOOL YEAR –please check one.

_____I will pick up any unused medication at the end of the school year.
_____Please send any unused medication home with my child. The school district will not be responsible for the medication once it is in the possession of my child.
_____Please discard any unused medication.
*Parent/Guardian signature_____ Date_____

Revised 06/2/2016