

**Spearfish School District 40-2 MS/HS**

**AUTHORIZATION FOR MEDICATION ADMINISTRATION AT SCHOOL**



Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_ Time to be given: \_\_\_\_\_

Length of time medication is prescribed: \_\_\_\_\_

Additional Instructions: \_\_\_\_\_

I grant permission for the Spearfish School District 40-2 to administer medication to the student above as prescribed by a health care provider. I understand that I must provide all medication in its original pharmacy labeled container and am responsible for transporting all medications to and from the office. I hereby certify that the student identified above has previously had at least one dose of the prescribed medication listed above and did not have an adverse reaction from it. I understand that my child assumes responsibility for going to the school office at the specified times for medication. I release and waive any and all claims which I now have or may hereafter have against the Spearfish School District 40-2 and its employees arising out of the administration of or failure to administer the medication to the student or any adverse reaction by the student to the medication.

\_\_\_\_\_  
Parent / Legal Guardian Date

\_\_\_\_\_  
Spearfish School District Employee Date

**STUDENT SELF ADMINISTRATION OF MEDICATION**

I acknowledge receipt of and/or have a written treatment plan prepared by a health care provider for managing health conditions requiring emergency medication. I certify/confirm that my student has been fully trained and can take medicine on his/her own. I consent to my student carrying, storing, and giving him/herself **ONE DOSE** of the medicine listed on this form in school. The student understands the expected response to the medication and what side effects and adverse responses should be reported to an adult. I am responsible for giving my student this medicine in bottles or boxes as previously described.

I am responsible for monitoring my student's medication use and for all results of my student's use of this medicine in school. I understand that if my student uses the medication in a manner other than prescribed, the student may be subject to disciplinary action by the school, however, any disciplinary action may not limit or restrict the student's immediate access to the medication. The school district and its officers, employees or agents incur no liability for damage, injury or death resulting directly or indirectly from the self-administration of medication and indemnify and hold the school and its officers, employees and agents, harmless from and against any claims relating to the self-administration of such medication.

\_\_\_\_\_  
Parent / Legal Guardian Date

\_\_\_\_\_  
Spearfish School District Employee Date



**Spearfish School District 40-2 MS/HS**

**PERMISSION FOR OCCASIONAL OVER-THE-COUNTER (OTC) MEDICATIONS GRADE 6-12**

Student \_\_\_\_\_ Grade \_\_\_\_\_ School \_\_\_\_\_

Medication Allergies \_\_\_\_\_ Current Daily Medications: \_\_\_\_\_

*Optional permission for student to receive the following OTC medications in the school setting per the below protocols for the current school year.*

- Acetaminophen (Tylenol)                      Fever, headache, toothache, menstrual cramps, sore throat, muscle pain, earache.
- Ibuprofen (Advil, Motrin)                      Fever, headache, toothache, menstrual cramps, sore throat, muscle pain, earache.
- Midol    Relief of cramping, bloating, and headache associated with menstruation.
- Triple Antibiotic Ointment (Neosporin)                      First aid to help prevent infections in minor cuts, scrapes, abrasion, and rashes.
- Aquaphor    Dry, chaped, irritated skin.
- Anti-Itch cream (hydrocortisone 1%, Benadryl)                      Relief of itching due to skin rashes and or insect bites.
- Antihistamine (Zyrtec, Benadryl, Claritin)                      For systemic reaction characterized by rash, edema, and or mild to moderate respiratory distress due to environmental, food or insect allergies. Parents will be notified. Further emergency care will be facilitated as warranted by condition. May be given for seasonal allergies.
- Tums (calcium carbonate)                      Stomach upset, indigestion.
- Orajel    Temporary oral pain relief.

All medications will be dispensed according to label instructions for dosing and frequency at the discretion of the RN. Student's weights may be obtained as necessary for accurate dosing. The school is not able to supply medication for frequent or daily use. Any other medications not included in the above list, or medications that must be given on a regular basis, can be administered to your child but must be provided and presented in the original container.

All prescription medications require additional written permission of the parent/guardian for administration in the school setting.

*I hereby certify that my child has had at least one dose of the medication(s) requested. I understand that any school employee who administers this medication to my child will do so in accordance with the Practice Act of the SD State Board of Nursing. I release and waive any and all claims which I now have or may hereafter have against the Spearfish School District 40-2 and its employees arising out of the administration of or failure to administer the medication to the student or adverse reaction by the student to the medication.*

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_