BOLD Public Schools

I.S.D. # 2534 Bird Island-Olivia-Lake Lillian School District

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Over-the-Counter (OTC) Medication
Parent/Guardian Authorization Form

(To be renewed annually)

Parent/Guardian must complete and sign a form before school staff will give over-the-counter medications. Over-the-counter medications must be provided in the original labeled container. OTC medications will only be administered to a student according to the label directions, unless contrary written directions from a physician are provided.

Students in grades 7-12 may possess and use **nonprescription pain relief** in a manner consistent with the labeling, with written authorization from the parent/guardian permitting the student to self-administer the pain relief medication. The district may revoke a student's privilege to possess and use nonprescription pain relievers if the district determines that the student is abusing the privilege. This rule does not include any other over-the-counter medication, especially those possessing ephedrine or pseudoephedrine. (M.S. 121A.222)

Students may not share prescription or over-the-counter medications with any other student(s). Appropriate disciplinary action may be taken if necessary, upon the determination by the principal or his/her designee, after investigation that a violation of this policy has taken place.

STUDENT:_____ **BIRTH DATE:**_____

SCHOOL NAME:_____ **GRADE:**_____

Parent/Guardian Authorization

Medication	Dosage	Frequency	Duration (One Year)

Reason for Use:_____
Allergies: (food or medications) ____Yes ____No Please List:_____

This student is in grade 7-12 and I allow student to possess and self-administer the above pain reliever. ___Yes ___No

This student is both capable and responsible for self-administering this medication (subject to school policy):
____ No ____ Yes, supervised ____ Yes, unsupervised

- I request that the above medication be given at school per the above protocol.
- I release school personnel from any liability in the administration of this medication at school. I understand that medication will not necessarily be administered by a school nurse.
- I understand that to promote safety for my child, medication information may be shared with school personnel working with my child and with 911 personnel, if they are called.

My child needs medication on field trips. ___Yes ____No

Parent / Guardian Signature: (Required)_____ **Date:**_____

Home Phone Number:_____ Work:_____ Cell:_____

Return this form to the high school office or Fax 320-523-5410 / Attn: Tabitha