Trinity Lutheran School Over-The Counter (OTC) Medication Authorization Form

10247 S Prairie Rd. Red Bud, IL 62278 (618) 282-2881 Email: office@trinityredbud.com

Student Name:_____ DOB:_____ Grade:_____
Last First

Medication Allergies: NO_____YES_____ If YES, give name of medication(s):_____

Describe reaction:_____

OTC medications students may take while at school that will be provided by the school Secretary. BEFORE any OTC medication on hand is given, the parent/guardian will be notified and a follow up paper/electronic note signed by school staff administering medicine sent home with student. Medications may be added or deleted from this authorization form at any time during the school year by contacting the School Office. With parental consent, the following type of OTC medications may be made available to your child when needed.

Please check "YES" to authorize school staff to give your child the following medications while at school. *OTC medications are dispensed per package directions unless written directives are provided by a physician.*

Over-the-counter medication dispensed *per package* directions	Indications:	YES
Acetaminophen(Tylenol) or generic	Pain reliever/fever reducer	
Diphenhydramine(Benadryl) or generic CREAM	Irritated skin or rash	
Sunscreen	To prevent sunburns	
Cough Drops or Throat lozenges	Cough or Throat irritation	
Calcium Carbonate (Tums)	Stomach pain/indigestion	
Ibuprofen (Advil) or generic	Pain Reliever/fever reducer	

I give permission for medication(s) listed and marked "YES" above to be given to my child for self-administration at the office secretary's discretion or dispensed by designated personnel in the school office during school hours. This consent is good for the school year, unless revoked.

_____ _____ _____
Parent or Guardian Signature Telephone Number(s) Date

OFFICE USE ONLY:

Approved by:_____ Date:_____
Office Secretary Signature

Reviewed by:_____ Date:_____
Principal Signature

Trinity Lutheran School- Consent Form for Student medications

10247 S Prairie Rd. Red Bud, IL 62278 (618)282-2881 Fax: (618) 282-4045

I have read the medication label, and my child does not have any health problem that could be made worse by taking this medicine. My child is not taking any other medication at home that could interact with this medicine and cause unwanted side effects. This medication will be kept in a locked location in the school office and will be administered as indicated below for the current school year by the office secretary or designated employee.

Medications must be dropped off & picked up by the parent or designated adult at the end of the school year. Any medications not picked up will be destroyed.

Please give the medicine according to the following directions:

OVER-THE COUNTER Medication

Fill out & return to school with a medication in ORIGINAL container of age & dose appropriate medicine.

Student:_____ DOB:_____ Grade/Teacher:_____

Medication:_____Dosage:_____Expiration date:_____

Purpose:_____Times to be given:_____

Special Instructions:_____

Parent/Guardian's current daytime phone #:_____

_____

Signature of Parent/Guardian Printed name of Parent/Guardian Date

"I hereby release Trinity Lutheran School of Red Bud (Prairie) IL, its Faculty & Staff, from any and all liabilities resulting from my child carrying their asthma inhaler, epinephrine injector or diabetic supplies to and from school."

_____

Signature of Parent/Guardian Date

Trinity Lutheran School- Physician Request for Self- Administration of Medication

10247 S Prairie Rd. Red Bud, IL 62278 (618) 282-2881 FAX: (618) 282-4045

_____ _____

Name of Student Birthdate

_____ _____

City Zip Telephone #

TO:

Principal:_____

School:_____

The above named pupil has_____

(Name of Disease or Syndrome)

I am requesting that the above named student take the following medication during school hours.

_____

Name of Medication Type of Medication (Tablet, Liquid or Capsule)

_____

Dosage Time(s) to be given

_____

Possible Side Effects

I certify that_____ has been instructed in the use and self-

(Name of Student)

Adminstration of_____

(Name of Medication)

He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects.

I may be reached at the following phone # in the event of a reaction to the medication or an emergency

_____ _____

Phone # of Physician Signature of Physician Date

_____ _____

Address of Physician Print Name of Physician Date

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