Kettering City School District/St. Charles Borromeo School
OTC Medication Form

PARENT RELEASE FOR A STUDENT TO HAVE NON-PRESCRIBED (OVER-THE-COUNTER/OTC) MEDICATIONS FOR USE DURING THE SCHOOL DAY (limited to acetaminophen, ibuprofen, antacids, cough drops)

To: Mr. Bogle _____ _____ _____
(Principal) (Student's Teacher/Grade) (Date)

For: _____ _____
(Student's Name) (Student's Date of Birth)

Allergies: _____

Should you wish for your child to receive over-the-counter generic or name brand medications while at school, please complete and return this form to the nurse's office. This form will remain valid **until the end of the current school year.**

The following non-prescribed, over-the counter medications, will be maintained/stocked at the school. Please check the medication(s) that above student can recieve at school according to *manufacturer's dosage recommendations* :

☐ Acetaminophen (500mg/tablet)

☐ Ibuprofen (200mg/tablet)

☐ Antacids Tablets (500mg/chew tablet)

☐ Cough Drops

If your child requires a liquid or a chewable form of Acetaminophen or Ibuprofen, please PROVIDE the medication to the school and complete the following:

☐ **Acetaminophen (Tylenol):** _____ (dosage in mg) _____ (frequency)

☐ **Ibuprofen (Advil):** _____ (dosage in mg) _____ (frequency)

I, _____ (parent/guardian/foster parent) of the above-mentioned student, hereby authorize a licensed health professional or other designated personnel employed by the school to administer EACH of the medication(s) checked above.

Over the counter medication, for release, refers to medication in liquid, pill or caplet form. *Dosage cannot exceed manufacturer's dosage recommendations.*

We (I) have reviewed with our/my student the appropriate use of this medication. We (I) agree to hold the school district and its employees free from any and all responsibility for the results of such medication and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

We (I), the undersigned, will notify the school immediately if we change medication or terminate the use of this medication for any reason. When medication has been discontinued, if the parent provided supply, any remaining medication must be picked up by the parent within 2 weeks after discontinuation or it will be discarded by the school nurse. Parents must pick up medication by the close of the last day of school or it will be discarded.

_____ _____ _____
(Parent Signature) (Name of Parent Name Printed) (Date)

_____ _____
(Address of Parent) (Phone Number)

TO BE COMPLETED BY THE SCHOOL

School Nurse Signature: _____ **Date** _____

Last update: MAY 2020