LAKE LOCAL SCHOOL DISTRICT

OVER-THE-COUNTER MEDICATION REQUEST FORM

The following information must be completed and the form signed by parent/guardian in order for OVER THE COUNTER MEDICATION to be administered by school personnel.

Student Last Name _____ Student First Name _____

Building _____ School Year _____ Grade _____ Date of Birth _____

Student Address:_____

Medication:

_____ Neosporin ointment (or generic equivalent) for minor scrapes/cuts

_____ Calamine lotion/Caladryl or Benadryl lotion for itching/skin rashes

_____ Tylenol/Acetaminophen 160mg – every 6 hours by mouth for headache/minor aches

_____ Tylenol/ Acetaminophen 325mg – every 6 hours by mouth for headache/minor aches

_____ Tylenol/ Acetaminophen 500mg – every 6 hours by mouth for headache/minor aches

_____ Advil/Ibuprofen 100mg – every 6 hours by mouth for headache/minor aches

_____ Advil/Ibuprofen 200mg – every 6 hours by mouth for headache/minor aches

Other Medication:

Name of Medication	Amount of Medication	Time of Administration	How to Administer
Example: Tylenol	*325 mg*	*every 6 hours as needed for pain*	*tablet by mouth*
1.			
2.			

Date administration is to begin _____ Ending date _____

With full knowledge of any emergencies, dangers, and risks related to the administration of such medication by the Lake Local Schools employees, officers, or agents, we the undersigned, hereby waive all claims which might arise from said administration of medication to said minor child. We hereby assume full responsibility for the administration of such medication to said minor child and the results thereof. We agree to indemnify and hold harmless Lake Local School district, Lake Local Board of Education, its members, officers, employees, and agents from any and all liability relative to the administration of such medication.

My child's physician or other prescribing healthcare provider is aware that this medication is necessary for my child to take during the school day. My child has taken this medication before without side effects. I further understand that it is my responsibility to pick up any leftover medication at the end of the administration dates. I realize that this form will not be used next year or after the above dates.

- **All medications must be provided by the parent and delivered to school in its original container, labeled with the student's name and dosing instructions.**
- There must be notification to the school if there is any change in the medication instructions.
- Please provide any other information that will help insure the proper and safe usage of the medication.
- Prescription medications must be brought in prescription bottle with signed instructions from the physician.
- It is the responsibility of the parent/guardian to retrieve any remaining medication at the end of the administration period (or school year). Any unclaimed medication will be disposed of prior to the next school year.

_____ _____ _____/_____/_____

Parent/Guardian Signature Date Phone Numbers (Home/Work/Cell)

SCHOOL USE: Date Received: _____ By whom (initials): _____

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