



Maple Valley Public School District # 4

207 Broadway - P.O. Box 168
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Pat Windish, Superintendent
Cathy Janish, Business Manager
Dr. Michael Nygaard, 7-12 Principal
Jay Kocka, K-6 Principal

www.maple-valley.k12.nd.us

Authorization/Permission for Administration of OTC Medication

Student Name _____ Birth Date _____

Medications and health care procedures required during school which cannot be managed otherwise shall be administered **when the following are on file at the school:**

1. Parent signed, dated authorization/permission given to administer the medication/procedure.
2. Medication/equipment delivered to school **by the parent/legal guardian** in the **original packaging**.
3. Annual renewal of authorization/permission and/or immediate notification, in writing from the parent, and changes

Medication/procedure shall be administered by qualified staff and a record maintained.

Medication/equipment will be stored in a locked, secured area.

Please administer the following to the above-named student:

Please circle one or both **Tylenol** **Ibuprofen** **Other** _____
Medication
AS NEEDED **and/or** **Every** _____ **Hours**

<i>Route</i>	<i>Dose</i>	<i>Time given at school</i>	<i>Discontinue date/re-evaluation date</i>
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Reason for medication/procedure

Anticipated reaction/possible side effects

Parent/Guardian Authorization/Permission

I request the above pupil be given the medication/procedure while in school and school related activities. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication/procedure where the person administering the medication/procedure acts as an ordinarily reasonable, prudent person would under the same similar circumstances. **I agree to pick up remaining medication or it will be properly destroyed.**

Parent Signature

Date

Parent Address

Work Phone

Home Phone

Cell Phone