Authorization/Permission for Administration of
OTC/Non-Prescription 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**

Route Dose Time Given at School Discontinue date/re-evaluation date

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**

The Maple Valley Public School District does not discriminate on the bases of race, color, national origin, age, sex, or handicap in its employment policies/practices.