Over-The-Counter (OTC) Medication Authorization Form
2018-2019

Student Name:_____ Date of Birth:_____ Grade:_____
Last First

Medication Allergies: No____ Yes____ If Yes, Give name of Medication(s):_____

Describe Reaction:_____

OTC medications students may take while at school will be administered by office personnel. Medications may be added or deleted from the authorization form at any time during the school year by contacting the office. With parental consent, the following types of OTC medication may be given to your child when needed.
*****Parents/guardians are to supply the medication to the office in its original packaging.*****

Please check "yes" to authorize the office staff to give your child the following medication while on campus. OTC medications are dispensed per package directions unless written directives are provided by a physician.

Over-the-Counter Medication per package directions:	**Dose**	**Indications:**	**Yes**
Acetaminophen (Tylenol) or Generic		Pain reliever/fever reducer	
Diphenhydramine (Benadryl) or generic		Hay fever or upper respiratory allergies	
Cough drops or throat lozenges		Cough/throat irritation	
Calcium Carbonate (Tums)		Stomach pain	
Ibuprofen (Advil) or generic		Pain Reliever/fever reducer	
Other:			

I give permission for medication listed above to be given to my child for self-administration at the office staff's discretion.

_____ _____
Parent signature **Date**

PERMISSION FOR PRESCRIPTION MEDICATION

Date:_____ School: Moore Public Schools Year: 2018-2019

Student:_____ DOB:_____ Grade:_____

Medication Name:_____ Medication Strength: _____

Medication Form: _____ Amount per Dose:_____
(Capsule, Tablet, Liquid)

Doses Submitted:_____ Diagnosis/Illness:_____
(Amount provided to school.)

Possible Side Effects:_____

Special Instructions for Office Staff: _____

_____

Physician Signature:_____ Date:_____
Ph #: _____

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PARENT PERMISSION

I hereby give my permission for _____ to take the medication prescribed by our physician. I authorize the Office Staff to communicate with the above physician's office, if needed and may only include the prescription or treatment itself, implementation of the treatment in school and student outcomes of the treatment.

NOTE: The prescription medication is to be brought to school in the original container, appropriately labeled by the pharmacy.

_____ _____ _____
Printed Parent/Guardian Name Parent/Guardian Signature Date

Montana Authorization to Possess or Self-Administer Asthma, Severe Allergy, or Anaphylaxis Medication

For this student to possess or self-administer asthma, severe allergy, or anaphylaxis medication while in school, while at a school-sponsored activity, while under the supervision of school personnel, before or after normal school activities (such as while in before-school or after-school care on school-operated property), or while in transit to or from school or school-sponsored activities, this form must be fully completed by 1) the prescribing physician/physician assistant/advanced practice registered nurse, and 2) an authorizing parent, an individual who has executed a caretaker relative educational or medical authorization affidavit, or legal guardian.

Student's Name:_____ School:_____
Sex: (Please circle) Female / Male City/Town: _____
Birth Date: _____/_____/_____ School Year: _____(Must be renewed annually)

Authorization by Physician/PA/APRN:

The above-named student has my authorization to carry and self administer the following asthma, severe allergy, or anaphylaxis medication:

Medication: (1)_____ Dosage: (1) _____

(2) _____ (2) _____

Reason for prescription(s): _____
Medication(s) to be used under the following conditions (times or special circumstances):
_____
_____

I confirm this student has been instructed in the proper use of this medication and is able to self-administer this medication without school personnel supervision. I have formulated and provided to the parent/guardian or caretaker relative a written treatment plan for managing asthma, severe allergies, or anaphylaxis episodes and for medication use by this student during school hours and school activities.

_____ _____ _____
Signature of Physician/PA/APRN Phone Number Date

Authorization by parent, individual who has executed a caretaker relative educational or medical authorization affidavit, or guardian:

As the parent, individual who has executed a caretaker relative educational or medical authorization affidavit, or guardian of the above named student, I confirm this student has been instructed by his/her health care provider on the proper use of this/these medication(s). He/she has demonstrated to me he/she understands the proper use of this medication. He/she is physically, mentally, and behaviorally capable to assume this responsibility. He/she has my permission to self-medicate as listed above, if needed. If he/she has used epinephrine during school hours, he/she understands the need to alert the school nurse or other adult at the school who will provide follow-up care, including making a 9-1-1 emergency call.

I acknowledge the school district or nonpublic school and its employees and agents are not liable as a result of any injury arising from the self-administration of medication by the student, and I indemnify and hold them harmless for such injury, unless the claim is based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.

I agree to work with the school in establishing a plan for use and storage of backup medication. This will include a predetermined location to keep backup medication to which the student has access in the event of an asthma, severe allergy, or anaphylaxis emergency. I have provided the following backup medication: _____

I understand in the event the medication dosage is altered, a new "self-administration form" must be completed, or the health care provider may rewrite the order on his/her prescription pad and I, the parent/caretaker relative/guardian, will sign the new form and assure the new order is attached.

I understand it is my responsibility to pick up any unused medication at the end of the school year, and any medication not picked up will be disposed of.

I authorize the school administration to release this information to appropriate school personnel and classroom teachers.

Parent/Caretaker/Guardian relative signature: _____ Date: _____

(Original signed authorization to the school; a copy of the signed authorization to the parent/guardian and health care provider)
See generally Mont. Code Ann. § 20-5-420