OVER THE COUNTER MEDICATION CONSENT FORM

McFarland School District Health Services

Conrad Elvehjem Primary School Health Office	Waubesa Intermediate School Health Office	Indian Mound Middle School Health Office	McFarland High School Health Office
Phone: 608-838-4674 Fax: 608-838-4503	Phone: 608-838-4673 Fax: 608-838-4613	Phone: 608-838-4672 Fax: 608-838-4588	Phone: 608-838-4682 Fax: 608-838-4562

Medication Order/Consent Form may be faxed to the Student's School

STUDENT INFORMATION

Student Name _____ **Date of Birth** _____ **Grade/School** _____

Indication/Diagnosis _____ **Dose** _____ **Route** _____

Medication Name _____ **Strength** _____ **Frequency** _____

Time & Condition *(if given on as needed basis)* **dose to be given** _____ **Start Date** _____ **End Date** _____

OVER THE COUNTER (AS NEEDED) MEDICATIONS

Please select which medications/treatments (supplied by health services) may be administered to your student. Health Services has a standing doctor's order to administer the following medication/treatments to your child (as needed). The box must be checked and form signed before medication can be administered. The use of any over the counter medication requested to be given beyond the recommended use will require a Medical Provider Order and parent supply medication. A Health Office visit email will be sent for each medication administered during the school day.

- ☐ **Acetaminophen** (*Tylenol*)
  - ☐ Weight-based dosing **(Under Age 12)**
  - ☐ 1 (325mg) Tablet or chewable/liquid equivalent **(Age 12 & Up)**
  - ☐ 1-2 (325mg) Tablets or chewable/liquid equivalent **(Age 12 & Up)**
- ☐ **Allergy Eye Drops**
- ☐ **Antacid Tablets** *(Tums)*
- ☐ **Cough Drops** *(Cherry & Honey Lemon)*
- ☐ **Ibuprofen** *(Motrin)*
  - ☐ Weight-based dosing **(Under Age 12)**
  - ☐ 1 (200mg) Tablet or chewable/liquid equivalent (200mg) **(Age 12 & Up)**
  - ☐ 1-2 (200mg) Tablets or chewable/liquid equivalent **(Age 12 & Up)**
  - ☐ 1-3 (200mg) Tablets or chewable/liquid equivalent **(Age 12 & Up)**
- ☐ **Cetirizine** *(Zyrtec) – For mild-severe allergic reactions only. Parents will be notified via phone call if administered.*

☐ **Other: Medication Provided by Parent/Guardian** *(Complete Required Information Above)*

PARENT/GUARDIAN SIGNATURE (Required)

I give my permission to the designated school personnel to administer the above medication according to the directions provided, including on field trips. I agree to release from liability and hold the McFarland School District and its employees harmless in any and all events from the administration of this medication. I agree to notify the school, in writing, of any change in the orders. I further agree to keep the supply of the medication replenished as needed and understand only a month's supply can be stored at the school. I also give permission for the school nurse to communicate with the prescribing provider regarding this prescription. Medication must be sent in the original, LABELED MANUFACTURER OR PHARMACY CONTAINER.

Print Name _____ **Preferred Phone** _____

Parent/Guardian Signature _____ **Date** _____

Health Office Personnel Signature: _____ Date: _____