WHITE PINE COUNTY SCHOOL DISTRICT
Health Services Department
"Making a Difference"

PARENT AUTHORIZATION FOR ADMINISTRATION OF OVER THE COUNTER MEDICATION AT SCHOOL AND AFTER-SCHOOL ACTIVITIES. ***(Only students in 6-12 grades are allowed to self-carry with permission of parent/guardian, school nurse, and principal)***

Name of Student____________________________________Date of Birth____________________

Address____ School/Grade_______________

Condition for which the medication is administered____

Name of Medication, dose, and method of administration_____________________________________

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Time or indication for administration of medication____

Duration (dates) of administration: From_________to _____________(limit one school year)

PARENT/GUARDIAN AUTHORIZATION

[ ] I request that my child, named above, be permitted to carry and self administer the above medication.
[ ] I authorize White Pine County School district designee(approved by nurse) or nurse to administer the above medication.
I take full responsibility for this permission. I understand that the medication **must be in the original container, labeled with the student name and medication; and the manufacturer's recommendations will be followed at all times.** No more than a 45 school day supply of medication will be kept at the school. This medication will be destroyed unless picked up within one week after the end of the school year or end of the medical order. This medication **MAY NOT** be shared with any other person while being allowed to carry at school on the school grounds or at any school activity.

Parent Signature__________________________Date________________Phone number______________

Student Signature (only if self carry grades 6-12)_____________________________Date______________

We accept the parent request and/or physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

School Nurse Signature_____________________________Date______________________________

Principal Signature_________________________________Date ______________________________