SMEC

Southern Minnesota Education Consortium

Non-Prescription Medication Authorization Form

This form expires at the end of the current school year.

_____ _____ _____

Student's Full Name Date of Birth Grade

_____ _____ _____ _____

Address City State Zip

As this student's parent/guardian, I give permission for my child to receive the following over-the-counter medications during school hours or during after school activities. I agree to provide the medication my child needs in the original labeled container with the protective seal intact.

(Circle yes or no for each medication listed below.)

Over-the-Counter Medication			**Dosage**	**Frequency**
Acetaminophen (*Tylenol*) for headache, toothache, or minor pain	Yes ☐	No ☐		
Ibuprofen for headache, toothache, or minor pain	Yes ☐	No ☐		
Anti-itch cream or lotion	Yes ☐	No ☐		
Cough drops	Yes ☐	No ☐		
Tums (antacid)	Yes ☐	No ☐		

Is student allergic to any medications? If yes, please list:

_____

_____

I give permission to the SMEC school nurse or SMEC's designee to give my child the above mentioned medications for comfort measures. I further agree to indemnify or hold harmless SMEC and its agents from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information.

_____ _____

Parent/Guardian Signature **Date**

_____

Printed Name of Parent/Guardian

Best Contact Number during school hours _____