All **COUGH DROPS**, Creams, Over-The-Counter, & Prescription Medication

(Includes: Tylenol, Motrin, Aleve, and Benadryl Cream)

Need to be brought to school by parents **NOT** students

Each medication needs a Medication Authorization Form

(Located on next page & school health website)

HARRISBURG TIGERS

HARRISBURG SCHOOL DISTRICT 41-2

200 Willow St. P.O. Box 187
Harrisburg, South Dakota 57032
605-743-2567 office/ 605-743-2569 fax

MEDICATION AND TREATMENT AUTHORIZATION FORM

Please complete this form if the below named student must take medication during school hours and it cannot be given at home. Harrisburg School District requires this form be completed by the parent for over-the-counter medications and both parent and physician for prescription drugs before administering any medication. Medication must be delivered directly to the school nurse/aide or trained personnel by the Parent/Guardian or responsible adult in the original pharmacy or manufacturer's container. **For your child's safety and the safety of other children, K-5 students are not allowed to carry/self-administer any medication at school.** With the exception to Epi Pen and emergency inhaler. Renewal is required at the beginning of each school year.

To be completed by Parent/Guardian or Physician

Student's Name: _____ Date: _____

DOB: _____ School: _____ Grade/Teacher: _____ Bus - Yes ____ No ____

Parent/Guardian Name: _____

Home: _____ Wk: _____ Cell: _____ Email: _____

1. Diagnosis: _____ Allergies: _____
2. Name of Medication/Treatment: _____
3. Dosage/Amount Prescribed: _____
4. Route (by mouth, eye drops, intranasal, etc.): _____
5. Time Given: _____
6. Frequency (daily, weekly, as needed, etc.): _____
7. Duration (beginning date and discontinue date): _____
8. Possible Side Effects: _____
9. Any Special Instructions: _____

If this is an emergency medication, i.e. inhaler, EpiPen®, etc., has student been instructed to self-administer and may he/she do so? Yes _____ No _____

Physician's Name (prescription only): _____ Date: _____

Physician's Signature: _____ Telephone/Fax: _____

To be completed by Parent or Guardian (initial appropriate option)

Option I: _____ (initial) I request and authorize the school nurse/aide or trained personnel at the above named school to store and administer the medication/treatment prescribed on this form to my child. I understand the medication must be provided in a bottle, identifying the name and telephone number of the pharmacy, the patient's name, physician's name and dosage of the drug to be taken (if prescription), or in the original bottle (if over-the-counter). I understand the school and individuals involved will not be held liable for any adverse effects of the medication. I give permission for communication that may be necessary between the prescribing physician and school nurse to insure safe medication administration for my child. In the event of a school -sponsored field trip I understand that my child's medication will be sent with designated personnel (typically the teacher) in the amount to be administered during the activity unless otherwise specified by me. In addition, I understand I am responsible to pick up unused medication when my child is finished or within one week after the last day of school. If medication is not picked up within one week after school is out, it will be destroyed.

Option II: _____ (initial) I request and authorize my child to keep and self-administer his/her own medication at school. I relieve the school district and personnel of all responsibility associated with this self- administration. I understand this option is available only when it will not be a potential health risk to my child or others. Medications which can be self-administered include physician-ordered inhalers and EpiPens®, and over-the-counter medications (e.g. Ibuprofen, Acetaminophen, cough drops, Tums). Prescription medications may not be self-administered unless specifically approved by the school nurse/aide. Except for inhalers and EpiPens®, only medication for one day at a time may be brought to school. **(This option is only available to middle school, high school and K-5 students with EpiPens and emergency inhalers).**

Parent or Guardian Signature: _____ Date: _____

Reviewing Nurse's Signature: _____ Date: _____