

Colstrip School District #19

PERMISSION FOR OVER THE COUNTER MEDICATION

Name of Student _____ Birthdate: _____

School _____ Grade _____

Medication _____ Dosage _____ Time(s) to be taken _____

Method of Administration _____ Purpose of Medication _____

If given "as needed", please specify the minimum length of time between doses: _____

Number of day's medication will be given at school _____

Possible Side Effects _____

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- I give Colstrip Public Schools staff permission to communicate with the medical office about this medication. I understand oral and medications may be administered by nonlicensed staff members who have been trained and are supervised by a Registered Nurse.
 - Medication information may be shared with school staff working with my child and 911 staff, if they are called.
 - All medication is to be brought to school by a parent or guardian in the original container labeled with the name of student and the dosage to be given.

Date _____ Parent/Guardian Signature _____

Telephone Numbers: _____ (home) _____ (work) _____ (cell)

Reviewed by Registered Nurse: _____ Date: _____