Knox County Career Center

Authorization for Administration of Over-the-Counter Medications at School

______________________________ ______________ ______________

Student Name | Date of Birth | School Year

______________________________ ______________________________

Address | Lab Teacher

______________________________ ______________ ______________

Emergency Contact Name/Relationship | Phone Number | Grade

As this student's parent/guardian, I give permission for my child to receive the following medications during school hours. I agree that the medication to be administered will be from the school nurse's stock medications unless I choose to provide my own. If I choose to provide my own medication for my child, it will be in the original labeled container with the protective seal intact.

(Circle yes or no for each medication listed below. Physician to complete dosage and time/frequency)

(Parent to Complete)			**(Physician to Complete)**	
			Dosage	**Time/Frequency**
Acetaminophen (Tylenol) for headache, toothache or minor pain.	YES	NO		
Ibuprofen (Advil or Motrin) for headache, toothache, minor pain or menstrual cramps.	YES	NO		
Skin cream or lotion (Calamine, Benadryl anti-itch gel, Neosporin, Vaseline)	YES	NO		
Cough drops	YES	NO		
Tums (antacid)	YES	NO		

Medication Allergies: ____

Severe Reactions that should be reported to the physician: ______________________________

Student's Provider (Physician/Nurse Practitioner/Dentist) **Complete dosage and frequency above**

Provider's Signature: ______________________________ Date: ______________

Provider's Name: ______________________________ Phone: ______________

(Continued on next page)

I give permission to the Knox County Career Center school nurse or to an authorized designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless Knox Public Health or the Knox County Career Center 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 this information.

____ ____________________

Signature of Parent/Guardian Date

____

Parent/Guardian Name (Please Print)

How can we reach you during school hours?

________________________________ ________________________________

Number to call 1st Number to call 2nd

Check if you wish to be notified each time an OTC medication is given: _______