PARENT/GUARDIAN AUTHORIZATION for OTC MEDICATION ADMINISTRATION

I, the Parent/Guardian, request the staff of Bloomfield School District to assist in the administration of the medication NECESSARY DURING SCHOOL HOURS as ordered by the medical provider to my child.

Student Name: _____ SCHOOL ID: _____ DOB: ___/___/___ SY _____

Parent/Guardian Signature: _____ Date: ___/___/_____

Parent/Guardian Phone Number: _____

⬜ I consent to have the school health professional administer the following over-the-counter (OTC) medication to my student per their assessment findings for the noted conditions. I understand that it is my responsibility to provide this OTC medication to the health office and understand it will be labeled with my student's identification.
Parent/Guardian Initials: _____

⬜ I understand that for the safety of all students, all over-the-counter medication must be (a) transported to/from school by an adult and (b) kept locked in the health office. Students are not allowed to carry any medications while at school. Parent/Guardian Initials: _____

⬜ I understand that school health professionals are administering this medication to my student and release any and all liability from them. Furthermore, I agree to inform my student's primary healthcare provider that my student will/does occasionally take this medication. Parent/Guardian Initials: _____

⬜ I wish to be notified when my student requests this medication. Parent/Guardian Initials: _____

HEALTH ISSUE/CONCERN	NAME OF MEDICATION	DOSE

Comments/Concerns: _____
_____
_____

Refer to BSD Board Policy J-5381 © JLCD-E

Health Office Use Only
Received and counted by: _____
School Nurse Signature: _____ Date: _____/_____/_____

⬜ Medication has been entered into PowerSchool.