

*Do we have your permission to dispense  
OTC Medication to your child?*

- Yes; please complete form  
 No, please initial \_\_\_\_\_

<b>FOR OFFICE USE ONLY – DISTRIBUTION:</b> <input type="checkbox"/> School Office <input type="checkbox"/> Main Office <input type="checkbox"/> Homeroom: _____
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## Authorization for Administration of Over-the-Counter Medications at School

This form requires **BOTH** a parent/Guardian & Physician signature. Expires at the end of the current school year.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*Also, please mark if your child is allergic to any of these medications.*

Over-the-Counter Medication <i>*available at the school first aid office</i>	Ok to dispense? <i>*please circle Yes or No</i>			Provided by Parent/Guardian?		Dosage/ Mg	Time/ Frequency
	YES	NO	ALLERGIC?	YES	NO		
Acetaminophen (Tylenol) for headache, toothache, or minor pain							
Ibuprofen (Motrin/Advil) for headache, toothache, minor pain or menstrual cramps							
Anti-itch cream or lotion							
Antibiotic Ointment for minor cuts, scrapes, etc.							
Benadryl							
Cough drops (Ludens)							
Antacid (Tums)							
OTHER – <i>must be provided by Parent/Guardian, in original container and checked in by an adult at Main Office:</i>	LIST MEDICATION:						

\*You will be informed when over-the-counter-medication is given to your child.

Severe reactions that should be reported to the staff: \_\_\_\_\_

**Student's Physician – may fax back to the school at 513-871-6428**

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone : \_\_\_\_\_ Fax: \_\_\_\_\_

As the parent/guardian of this student, I give my consent to Springer School & Center and its staff to administer the preceding medications to my child, in accordance with the special instructions which I have given herein and I, on behalf of myself, my child, heirs, executors, administrators, assigns, as well as my child's guardian(s) and other parent, do hereby fully release and discharge the Springer School & Center, its trustees, assigns and successors, employees and agents from all claims of damages and actions whatsoever, including medical and emergency expenses, arising from the giving of such medication. **I further understand that parents/guardians are required to hand deliver the child's medication to the main office in the original bottle and that medications will be stored in the school office depending on my child's medication schedule. I also understand that Springer staff cannot release medication to a child to carry home on his or her person.**

*By signing, I hereby acknowledge receipt and understanding of the above policy.*

Name of Parent/Guardian (please print): \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**How can we reach you during school hours?**

Work phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_