SPRINGER School and Center

FOR OFFICE USE ONLY – DISTRIBUTION:
☐ School Office
☐ Main Office
☐ Homeroom: _____

Authorization for Administration of Over-the-Counter Medications at School – 2024-25

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

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: _____

REV. May 2024

☐ Updated Database _____