McKinney Independent School District
School Health Services

OVER THE COUNTER Medication Administration

Valid for school year _____

PARENT'S REQUEST FOR THE ADMINISTRATION OF **OVER THE COUNTER** MEDICATION TO A STUDENT

Over the counter (OTC) medication MUST be in the original container with the student's name on the container. Due to limited storage, no more than a **30 count container** shall be stored in the clinic. OTC medications may be left in the clinic during the entire school year with a parent's signature. However, OTC medications will be given according to the label on the package unless otherwise directed by a physician. OTC medications will not be given for more than 5 consecutive days without a physician's signature.
NOTE: We are unable to store any medications at the school during the summer and will dispose of all medications left in the clinic after the last day of school.

Name of Student: _____ Date of Request: _____

Address: _____ Birth Date: _____

School: _____ Home Phone: _____

Teacher: _____ Grade: _____

Name of medication: _____

Condition for which medication is to be given: _____

Amount to be given: _____ Time to be given: _____

Special instructions: _____

Date medicine is to be discontinued: _____Expiration date _____

It is impossible to schedule the above-mentioned medication at a time other than school hours. I request that this medication be given by a school employee. I understand that the School District, Board of Trustees, and District employees shall not be held responsible for damages or injuries resulting from administration of this medication.

I consent to the release of the medical information contained on this form to school officials who have a legitimate educational interest in the information, according to MISD Board Policy and the Family Education Rights and Privacy Act. I give permission for the release of confidential information regarding my child's specific health problems to third parties, other than school officials, as required to facilitate medical care and/or treatment of my child. I authorize the nurse and the prescribing physician to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

_____ _____

Signature of Parent or Guardian *Daytime Phone Number*