Pittsville Public School District
20____- 20____ School Year

Non-Prescription
Medication Administration Authorization
Release and Indemnification Agreement

Student:	**Date of Birth:**	**Grade:**

PART I—TO BE COMPLETED BY THE PARENT/GUARDIAN

Please administer the following non-prescription medication(s) according to the specifications indicated below. I understand a Prescription Medication Order and Administration Authorization *is required for any non-prescription medication that needs to be given* ***for more than 5 consecutive days****.*

List Medication Allergies: ☐ none

Medication Name ***Per pkg dosing = manuafacturer's recommendations***	**Dose**	**Route**	**Time(s)**	**Reason for Use and Special Instructions**	**End Date**
☐ Acetaminophen (*Tylenol*): ***circle one*** • Children's • Junior's • Adult	☐per pkg* ☐other:	oral	☐per pkg* ☐other:	☐pain or fever ☐other:	☐ end of school year ☐ other:
☐ Ibuprofen (*Advil, Motrin*): ***circle one*** • Children's • Junior's • Adult	☐per pkg* ☐other:	oral	☐per pkg* ☐other:	☐pain or fever ☐other:	☐ end of school year ☐ other:
☐ Diphenhydramine (*Benadryl*)	☐per pkg* ☐other:	oral	☐per pkg* ☐other:	☐hives, itching ☐other	☐ end of school year ☐ other:
☐ Cough Drops	☐per pkg* ☐other:	oral	☐per pkg* ☐other:	☐cough ☐other	☐ end of school year ☐ other:
☐ Other:					

I hereby request and authorize Pittsville Public School District (PPSD) principal-designated personnel to administer the non-prescribed medication indicated above to my child. I agree to release, indemnify, and hold harmless PPSD and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering this medication to my child, provided staff are following the specifications as indicated. I have read the PPSD medication policy and protocol as outlined on the back of this form and assume the responsibilities as required.

Parent/Guardian Signature:_____**Date:**_____

Phone: (H)_____ **(C)**_____**(W)**_____

PART II—TO BE COMPLETED BY THE SCHOOL NURSE

☐ Parent/Guardian consent signed and dated
☐ Non-prescription medication in original container with the manufacturer's label intact and readable
☐ Non-prescription medication label and parent/guardian request are consistent
☐ Entered in Skyward: initials_____ date_____

School Nurse Signature:_____ Date:_____

Pittsville Public School District
Medication Policy and Protocol

1. Prescription medication to be administered in school or during school-sponsored activities requires the written order from the prescribing licensed healthcare provider (LHP) and parent/guardian written consent.
2. The Licensed Healthcare Provider (LHP) who may prescribe medication must be an MD, DO or Nurse Practitioner.
3. Non-prescription medication requires parent/guardian written consent.
4. Non-prescription medication will require a written order from a LHP if needed to be given for more than 5 consecutive days.
5. The parent /guardian is responsible for completing Part I and obtaining the LHP written order on Part II for prescription medication(s).
6. A new Prescription Medication Order and Authorization form is required:
    - at the beginning of each school year
    - with any new prescription medication order
    - with any changes in current medication (i.e. dose, time, etc.)
7. Written communication of medication discontinuation is required from the parent/guardian.
8. Medication must be delivered to the school health office by the parent/guardian or an adult designated ***in writing*** by the parent/guardian, otherwise it ***will not*** be accepted.
9. All prescription medications must be in the original container with the pharmacy label intact and readable.
10. All non-prescription medications must be in the original container with the label intact and readable.
11. Physician samples must be appropriately labeled.
12. It is strongly recommended to administer the first dose of a new medication at home to observe student for any potential reactions
13. Parent/Guardian or an adult designated ***in writing*** by the parent/guardian must collect any expired or unused prescription or non-prescription medications by the end of the school year or the medications will be destroyed.
14. Students may not self-administer controlled medications.
15. Licensed Healthcare Provider (*MD, DO, or Nurse Practitioner*) **and** parent/guardian consent are necessary to self-carry and/or self-administer emergency medications such as inhalers and EpiPens.
16. The student should report the use of their inhaler if he/she does not experience improvement in breathing.
17. ***EpiPen*** : the student ***MUST REPORT*** use of
18. ***EMS (911)*** will be notified after the use of EpiPen regardless of symptoms.
19. The school registered nurse (RN) will call the prescriber as allowed by Health Insurance Portability and Accountability Act (HIPAA) if any concern arises related to the medication prescribed.

Parent/Guardian Initials:_____ Date:_____