wheaton christian GRAMMAR SCHOOL

Over-the-Counter Medication Administration Authorization

2024-2025 School Year

Student Name_____ Date of Birth_____

Grade_____ Teacher_____

Student's Weight (in pounds for dosage purposes) _____

I authorize that the above-named student may be administered the following OTC medications, according to the guidelines set forth below, during the school day if symptoms warrant pharmaceutical intervention according to the registered nurse's clinical judgment in order to maintain the student's attendance at school:

PARENT/GUARDIAN-PROVIDED OTC MEDICATIONS: *only FDA-approved pharmaceuticals in their original containers will be accepted

Medication Name	Dosage	Frequency

Administration of over-the-counter medication by the WCGS Registered Nurses is contingent upon the following guidelines:

1. This form must be fully completed, signed by the parent/guardian, and turned into the Nurses' Office **BEFORE** any OTC medications will be administered to the student without a dose-by-dose verbal or written authorization.
2. This form is **NOT required** to be on file if the parent/guardian prefers to give pre-authorization before every dose of OTC medication is given.
3. The requested OTC medication must be an FDA-approved pharmaceutical. Naturopathic supplements, ointments, oils, creams and sprays will not be accepted.
4. The requested OTC medication must be brought to the school office in the *original pharmaceutical container labeled with the student's name*.
5. **The registered nurse on duty will be the ONLY staff member** at WCGS administering these medications without direct verbal authorization from the parent due to the **clinical assessment** that is required prior to medication dosing. The registered nurse may choose to delegate administration to a trained staff member if the situation warrants after the clinical assessment has been completed.
6. The school will **maintain a written record** of any medication dispensed, including the student's name, name of medication, date/time it was administered, and by whom, and the reason for administration. This documentation will also be forwarded to the authorizing parent/guardian via email as notification after the medication has been given.
7. This document is in effect for the **entire school year**.
8. The authorization that this form provides **may be revoked** by the parent/guardian at any time. The revocation must be provided in writing, indicating the expiration date of the authorization.

Please review and complete side 2

PARENT/GUARDIAN AUTHORIZATION (apply initials to each statement)

_____On my behalf, I authorize the Wheaton Christian Grammar School registered nurses to administer to my child the specified OTC medications in the manner described on the medication manufacturer's labeling, **or if a larger than recommended dosage is required, according to the attached Physician's Order**.

_____I certify that **I have legal authority to consent to medical treatment** for the student named within this document, including the administration of medication at school. In addition, I agree to release, and hold harmless and indemnify, the school, its employees, agents and volunteers, from and against any and all liabilities, claims, damages, causes of action and possible causes of action whatsoever arising out of or related to any loss, damage or injury (including death) incurred or resulting from the administration or attempt to administer said medication.

_____I understand that the **registered nurse uses clinical judgement** to assess the need for any medication administration and will make the **final decision** to determine if symptoms warrant pharmaceutical intervention in order to maintain the student in school and is in the best interests of the student.

_____I affirm that I have administered the requested OTC medications to my child prior to the date of this authorization and he/she **has never had negative side effects or complications due to ingestion of them.**

_____I hereby confirm that I have reviewed and understand Wheaton Christian Grammar School's policy regarding the administration of OTC medications during school hours. I also confirm that I have fully read this authorization document.

Parent/Guardian Signature_____**Date**_____

Cell Phone Number_____**Email** _____

OFFICE USE ONLY

Order reviewed by school RN:

Signature_____Date_____

Notes_____