Kenai Peninsula Borough School District Health Services **E 5141.21(b)**

MEDICATION AUTHORIZATION FORM – Non-prescription Medication

Student Photo Here

STUDENT _____ **GRADE** _____

SCHOOL _____ **BIRTHDATE** _____

MEDICATION Allergies: _____

As parent/guardian of the above-named student, I request the School District to give medicine for the following condition(s). ***(Check all that apply***)

CONDITION: **Headache** **Cramps** **Dental** **Pain** **Other:** _____

MEDICINE: **Acetaminophen** **Ibuprofen** **Benadryl** **TUMS** **Other:**_____

Dose: _____**Frequency:** _____**Specify Time:** _____ **or As Needed:** _____

Side Effects_____**Special Instructions for administration**_____

NONE: ☐ Do not administer any over-the-counter medication.

I understand that the school is not legally obligated to administer medication to my child. Therefore, I agree to defend and hold harmless, the school district and its employees from any liability for the results of the medication or the manner in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements. Medication request must be deemed necessary to maintain or improve health and participation in the school program. Each request will be assessed for the most appropriate intervention and will be given at the standard dosage recommended by manufacturer. I will notify the nurse if I give this medication to my child before arrival at school while this request is in effect to prevent overmedicating. I agree to supply medication for my student in its original packaging (small bottles only, please). I also affirm that my child has taken this medicine at least two times in the past without any adverse side effects. **I understand that the medicine will be destroyed unless picked up by the end of the last student school day of this year. Medicines will not be kept by the school over the summer break per DEA regulations.**

Parent/Legal Guardian Signature: _____**Printed Parent Name:** _____

Date: _____

☐**Approved or** ☐**Denied School Nurse Signature**_____**Date**_____

OVER THE COUNTER MEDICATION ADMINISTRATION RECORD

MED~DATE~TIME~INITIALS	MED~DATE~TIME~INITIALS	MED~DATE~TIME~INITIALS

Initials_____ **Name**_____ **Initials**_____ **Name**_____

Initials_____ **Name**_____ **Initials**_____ **Name**_____

Revised 3/20/2025