SPRINGBORO SCHOOLS
People First / Always Growing / Better Together

Student Health Services

OVER-THE-COUNTER (OTC) MEDICATION FORM

THIS FORM IS VALID FOR CURRENT SCHOOL YEAR ONLY.
****Medication will only be given 2 Times per Week. If the student requires the medication ongoing or more frequently, please complete the Prescription Medication Form to include the Medical Providers Signature for the orders.**

Start Date: _____ ***End Date:*** _____

Student Name		**DOB**	
Parent Name		**Grade**	
School		**Teacher**	

To be Completed By the Parent/Guardian:

Name of Medication:	EXP. Date: _____
Dosage:	
Time to be Administered:	
Special Storage Instructions:	

I, hereby, acknowledge reading this request to administer medication; and understand its content, as well as the content of the Board of Education policy.

1. Provide the school with the medication in the original bottle/box with all drug related information and expiration date visible.
2. Notify the school if the medication, dosage, or procedures is changed or is to be eliminated.
3. Release authorized school personnel from all liability, cause of action, or any other responsibility for administering said medicines as noted above.
4. The Board Substance Abuse Policy and the Student Code of Conduct Policy would apply to any student dispensing, selling, and/or having possession of medication at school.

Parent Signature	**Telephone Number**

I, hereby, acknowledge reading this request to administer medication; and understand its content, as well as the content of the Board of Education policy.

Clinic Nurse Signature	**Date**