

**MT VERNON COMMUNITY SCHOOL CORPORATION
AUTHORIZATION TO CARRY OVER-THE-COUNTER MEDICATION
GRADES 6-12 ONLY**

This form must be completed in its entirety to authorize your student to carry certain over-the-counter (OTC) medications. OTC medications that will be considered for self-carry and administration include acetaminophen, ibuprofen, diphenhydramine, anti-diarrheal, anti-nausea, anti-gas, antibiotic ointments, anti-itch cream, Midol, nasal spray, throat spray, and OTC migraine relief medications. ***OTCs that CANNOT be carried by students under any circumstances include medications that contain pseudoephedrine or dextromethorphan.*** These medications will require a completed Request To Administer Medication Form and must be stored in the clinic. Responsibilities of carrying and self-administering OTC medications include:

1. Prior to the student carrying the over-the-counter medication in the school building, this Form must be turned in to the school clinic and the medication verified by the health assistant or school nurse.
2. Medication must be brought to school in its original packaging and must have the student's name written on it in permanent marker.
3. The parent must educate the student on how and when to self-administer the medication in their possession. The school is not responsible for providing such instructions.
4. The student agrees that they will not share their medication with any other student under any circumstances.

To Be Completed by Parent/Guardian

Student's Name: _____
Name of Medication: _____

I request that my student be permitted to carry and self-administer the medication named above. I certify that I have legal authority to consent to medical treatment for the student named above. I have instructed my student on the proper administration of this medicine, including when, why and how to take this medication. I understand that the principal or his/her designee may at any time confirm that my student is complying with the terms Form by checking the contents of the over-the-counter medication package. I further understand that a violation of the terms of this Form will result in my student no longer being permitted to carry medication and being subject to disciplinary consequences. I hereby release and discharge and further agree to indemnify, hold harmless, defend or reimburse Mt. Vernon Community School Corporation, Mt. Vernon Community School Corporation Board of Directors, its employees, agents, representatives, and all other officials, from any and all claims, actions, suits, losses, costs, expenses and liability in case of accident or other mishap because of negligence in administering such medication or because of side effects, illness or any other injury which might

occur to my child through administering such medication. And, I hereby release said aforementioned board, corporation, employees and officials from any liability, suit or claims of whatever nature and kind, which might arise as a result of administering the medication in accord with this request. I accept legal responsibility for my child should the above medication be lost, given or taken by a person other than the above named student. If this should happen, the privilege of carrying medication will be revoked. I further release Mt. Vernon Community School Corporation and its employees of any legal responsibility when the above student administers his/her own medication.

Signature of Parent/Guardian

Date

Parent/Guardian's Telephone Number: _____

To Be Completed by Student

I have been instructed by my parent/guardian on the proper administration of this medication. I understand the symptoms that warrant taking this medication, and I understand how much of this medication to take. I will not allow another student to take my medication under any circumstances. I understand that the principal or his/her designee may at any time confirm that I am complying with the terms of this Form by checking the contents of the over-the-counter medication package. I am aware that should another student take my medication or should I violate any term of this Form, I will no longer be permitted to carry medication and will be subject to disciplinary consequences as stated in the student discipline policy.

Signature of Student

Date

To Be Completed by School Personnel

I have seen and verified the above medication is in its original container. I have also documented and notified building administration of the students' authorization to self-administer and carry.

Signature of School Personnel

Date