AUTHORIZATION TO CARRY OVER-THE-COUNTER MEDICATION
GRADES 7-12 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 physician statement on Form 5330 F1, and must be stored in the clinic. Responsibilities of carrying and self-administering OTC medications include:

1. Form C525-F must be turned into the school clinic before the student can carry over-the-counter medication in the school building. Once the health assistant has verified the form is appropriately completed and verified the over-the-counter medication the student is carrying, a "medication pass" will be issued that the student must keep with the medication at all times.

2. A one day's dose supply is all that may be carried by the student. This supply is determined by the package's recommended dosage instructions.

3. Medication must be brought to school in its original packaging and must have the student's name written on it in permanent marker.

4. 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.

5. 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 after a medication pass has been issued to my student, the principal or his/her designee may at any time confirm that my student is complying with the terms of Policy C525 and this Form by checking the contents of the over-the-counter medication package. I further understand that a violation of the terms of Policy C525 or this Form will result in my student no longer be permitted to carry medication and being subject to disciplinary consequences as stated in the student discipline policy.

I hereby release and discharge and further agree to indemnify, hold harmless, defend or reimburse Greenfield-Central Community School Corporation Board of Directors, The Greenfield-Central Community

School Corporation, 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 the Greenfield-Central 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 after a medication pass has been issued to me, the principal or his/her designee may at any time confirm that I am complying with the terms of Policy C525 and 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 Policy C525 or 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 the above labeled medication bottle and have issued the student a medication pass to carry with this medication.

_____ _____

Signature of School Personnel Date