OVER THE COUNTER (OTC) MEDICATION MANAGEMENT FORM

Name of Child/Student:	Date of Birth:	Grade:	School:
Condition/ Diagnosis of Child:			

For this diagnosis, I give consent to the medications listed below:

Note: ENTIRE school year includes summer school sessions following the current school year. By ECASD policy staff may administer medications only within 30 minutes before or after the scheduled time.

MEDICATIONS (Please Indicate if Scheduled or As Needed)								
Medication Name:	Route:	Total Dose:	Frequency (scheduled or as needed)	Duration: Entire School Year *(write ESY below)* OR Specific Dates *(write dates below)*	If as needed, give for symptoms listed below	Contact me if child develops any of the conditions or reactions to medication listed below *(if none, write n/a)*	Student may carry?	Student may self-administer?
							☐ Y ☐ N	☐ Y ☐ N
							☐ Y ☐ N	☐ Y ☐ N
							☐ Y ☐ N	☐ Y ☐ N

Additional directions/instructions:_____

_____

Note: Designated school personnel can call me at any time with questions or concerns related to my child's condition and medications. I acknowledge I will have to complete a new medication consent form when there are changes in the medication or in the administration of medication for this child/student.

I agree and accept my responsibilities regarding school administration of medication to my child, that is, to:

- Notify the school of my child's needs.
- Complete this form, which grants the school permission to administer medication to my child in the dosage indicated. This *"Over the Counter (OTC) Medication Management Form"* is valid only for the current school year and the summer immediately following.
- Deliver this form and the initial supply of medication to the school.
- Make sure that each medication is in the original manufacturer's container that lists the ingredients and recommended dose.
- Assume full responsibility for the safe delivery of medications to appropriate school personnel.
- Notify the school, in writing, if the medication is discontinued during the school year.
- Hold the Eau Claire Area School District, its employees and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of or exchange of information regarding the medications noted on this *"Over the Counter (OTC) Medication Management Form"* at school or at school-related events.

MY SIGNATURE INDICATES THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION:

Parent/Guardian PRINTED Name:_____

Parent/Guardian Email Address:_____ Parent/Guardian Phone:_____

Parent/Guardian Signature:_____ Date:_____

Revised 7.29.2024