

**Authorization to Give Medication**

**Authorization To Give Prescription or OTC Medication**

If your child requires prescription medication during school hours, or you choose to bring in OTC medication, we **must** have this form completed and signed by the parent/guardian **AND** signed by a healthcare provider prior to administering or accepting the medication. This form may be emailed, faxed or turned into the school. Any changes to the medication will require a new authorization.

School Year \_\_\_\_\_

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Allergies: \_\_\_\_\_

1. Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Dosing Instructions: \_\_\_\_\_

Specific time to give: \_\_\_\_\_ Route: \_\_\_\_\_

Start med when form rec'd:  Yes  No Other: \_\_\_\_\_ Stop at end of school year:  Yes  No Other: \_\_\_\_\_

2. Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Dosing Instructions: \_\_\_\_\_

Specific time to give: \_\_\_\_\_ Route: \_\_\_\_\_

Start med when form rec'd:  Yes  No Other: \_\_\_\_\_ Stop at end of school year:  Yes  No Other: \_\_\_\_\_

3. Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Dosing Instructions: \_\_\_\_\_

Specific time to give: \_\_\_\_\_ Route: \_\_\_\_\_

Start med when form rec'd:  Yes  No Other: \_\_\_\_\_ Stop at end of school year:  Yes  No Other: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature Phone Date

\_\_\_\_\_  
Print Physician's Name Address

**\*Parent/Guardian must bring prescription medication to the school in a current, original, pharmacy-labeled container. All prescription medicine will be counted upon receipt with parent/guardian and school personnel. OTC medication must be in a small unopened container.**

I hereby authorize school personnel to administer the above medication to my child and release the school, the Oldham County Board of Education and its employees from any liability that may occur from the administering of this medication according to the instructions on this form. Parent/Guardian hereby gives consent to the Oldham County Board of Education and its employees and for the child's physician to discuss his or her medical condition or medication administration referenced above with school or district personnel to assist them in planning for my child's care while at school or school events.

\_\_\_\_\_  
Parent/Guardian Signature Phone Date



**Authorization to Give Medication**

**Authorization For Administration Of Stock Over the Counter (OTC) Medication**

School Year \_\_\_\_\_

Beginning the 2025-26 school year, Oldham County Schools will offer a selection of over-the-counter (OTC) medications for students who may need them during the school day. These medications will be available at no cost to families, but require your permission to be administered.

With your consent, trained school staff—including the school nurse—may provide your child with age-appropriate doses of the following OTC medications for minor health concerns such as headaches, allergies, or minor injuries.

**Stocked OTC Medications**

The following medications may be administered based on manufacturer instructions and school protocols:

1. **Acetaminophen** (e.g., Tylenol) – For pain relief
2. **Ibuprofen** (e.g., Advil, Motrin) – For pain relief or inflammation
3. **Antihistamine** (e.g., Benadryl) – For insect stings, rashes, eczema, hives, or allergy symptoms
4. **Cough Drops or Lozenges** – For sore throat or cough relief
5. **Topical Antibiotic Ointment** (e.g., Triple Antibiotic, Neomycin free) – For minor cuts or scrapes.
6. **Sting Relief/Anti Itch Cream** (e.g., Diphenhydramine Cream, Calamine lotion) – For minor skin irritations
7. **Aloe Vera Gel** - For temporary relief of sunburn, windburn, or mild skin irritation
8. **Menstrual Pain Relief** (e.g. Midol) - Temporary relief of menstrual symptoms
9. **Eye Wash** (e.g., Saline Solution) - For relief of minor eye irritation or dryness
10. **Antacid** (e.g., Tums) - For temporary relief of stomach upset, heartburn, sour stomach, acid indigestion

All medications are stored and maintained by the school and authorized under standing medical orders from a board-certified healthcare provider.

**Notification Policy**

You will be contacted by phone before any OTC medication is given to your child, unless immediate treatment is necessary (e.g., a severe allergic reaction). In those cases, you will be contacted as soon as possible afterward. All medication administrations are documented and kept on record at the school.

**Parent/Guardian Consent**

By signing below, you are authorizing trained school staff to administer the approved OTC medications to your child when needed. Please note:

- Medications will be given in accordance with age guidelines.
- You may revoke your permission at any time by notifying the school in writing.
- Please inform the school of any allergies, medical conditions, or current medications your child is taking that may impact OTC use.
- This consent is only valid for the current school year.

**Student Information**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

**Parent/Guardian Consent**

- I give consent for my child to receive the listed stock OTC medications as needed, with prior notification as outlined above.
- I do not give consent for my child to receive any stock OTC medications at school.

*\* If you do not give consent for stock medications and prefer to provide your own, a separate medication form with physician's orders will be required before any medication can be administered at school.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization to Give Medication**

**AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION  
EXTENDED DAY/OVERNIGHT FIELD TRIPS**

Students may be authorized to self-administer their own medication while on school-sponsored extended day or overnight field trips. All prescription and non-prescription medications shall be kept with an adult who is an Oldham County School employee unless student has permission to carry emergency medication signed by a physician (Glucagon, Epi Pen, Inhaler, Diastat). At the appropriate time, the medication will be available to the student to self-administer in the presence of the school employee.

- All prescription medication must have a pharmacy label that includes the student's name.
- Non-prescription over-the-counter medication must be in the original container and marked with the student's name.
- ONLY PROVIDE THE AMOUNT NEEDED FOR THE TRIP.
- Aspirin and medications containing narcotics or sedation for pain relief will not be administered for the child's safety.

**ONE MEDICATION PER FORM**

If your student requires medication during the field trip, please complete the following:

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Medication \_\_\_\_\_ Reason for Medication: \_\_\_\_\_

Strength (mg): \_\_\_\_\_ Dose (how much): \_\_\_\_\_

Time(s) of administration: \_\_\_\_\_ Route: \_\_\_\_\_

Allergies: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Special storage requirements: \_\_\_\_\_

- By signing below, I acknowledge that the school employee is **NOT** responsible for administering the medication.
- I agree to hold staff members and the OCBE harmless for any injuries resulting from the ingestion of the medication or reaction to the medication unless the injury was caused by the Board of Education employee's negligence.
- I have instructed my child on the use and necessity of this medication and that he/she is capable of administering the medication independently.

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

In case of emergency please contact me at:

\_\_\_\_\_  
*Phone*

\_\_\_\_\_  
*Alternate Phone*

DATE <i>(new line for each date)</i>	TIME	TIME	TIME	TIME	STUDENT SIGNATURE

Name of Medication received, strength (mg), and amount received:  
Name: \_\_\_\_\_ Strength: \_\_\_\_\_ Amount: \_\_\_\_\_  
Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_