Northome School ISD# 363
School Year 2026-2027
Parent/Guardian Supplied OTC - Over The Counter Medication Authorization

Student:_____DOB:_____Grade:_____

Allergies:_____

Parent/Guardian:_____Phone:_____

Medication (include dosage):_____

Reason(s):_____

Time to give dose:_____

Other medications this student is taking:_____

- All medications must come to school in the original pharmacy container.
- Whenever possible medication should be given at home instead of school.
- Students in grades 7-12 may be able to self-carry medications, please reach out to the health office if you would like your student to carry medication in backpack/locker.
- No medication containing ephedrine or pseudoephedrine will be allowed.
- Please notify the nurse if there are any changes in the medication(s) to be given (dosage change/discontinued/hold/etc.) A new order will be needed to make changes.
- I give permission for the school nurse to communicate with teachers/staff about the action and side effects of this medication.
- I give permission for the medication(s) listed above to be given to my student according to the manufacturer label directions and administration by designated personnel as delegated by the School Nurse/Health Office.
- I release school personnel from any liability in relation to this request when the medication is given per manufacturer label.

Parent Signature:_____**Date:**_____

Please contact the Health Office with any questions or concerns @ 218-897-5275 ext. 156