



SIBLEY EAST PUBLIC SCHOOLS

HEALTH SERVICES

202 3rd Ave. N.W.

PO Box 1000 | Arlington, MN 55307

(High School)P: 507.964.2292 | F: 507.964.8245

(Elem)P: 507.237.3317 | F: 507.237.3300

SELF CARRYING NON-PRESCRIPTION PAIN MEDICATION FOR STUDENTS

Student Name _____ Birth Date _____

School _____ Grade _____ Teacher _____ School Year _____

MEDICATION _____

PURPOSE OF MEDICATION _____ Dose _____
(per bottle instructions)

I give permission for this student to self-carry/self-administer the medication listed above.

PARENT/GUARDIAN AUTHORIZATION

1. The medication must be a non-prescription medication that does not contain aspirin, ephedrine/pseudoephedrine as the sole active ingredient or one of its active ingredients.
2. I will provide this medication in the original, properly labeled container.
3. I instructed my child on the use and administration of this medication.
4. If the dosage exceeds the manufacturer's label, a licensed prescriber order will be required. Renewed each school year.
5. I understand that my child will be permitted to carry the medication as long as he/she does NOT endanger other persons and does not misuse it. If misuse occurs, school administration/staff can confiscate the medication.
6. I release school personnel from any liability in the event that any reaction results from the administration of this medication.
7. I understand my child is entirely responsible for the use of this medication and the use of this medication will NOT be monitored at school.

Parent/Guardian Signature _____ Date _____

STUDENT AGREEMENT

I WILL:

1. Take the medication according to the label directions or my licensed provider's order.
2. NOT allow anyone else to use this medication
3. Notify the health office personnel if my symptoms worsen, reoccur or I suspect I am experiencing side effects from the medication.

STUDENT SIGNATURE _____ DATE _____

DISTRICT SCHOOL NURSE SIGNATURE _____ DATE _____