CEDAR MOUNTAIN PUBLIC SCHOOLS
ISD #2754

Cedar Mountain Middle/High School
PO Box 188
Morgan, MN 56266
Phone: (507) 249-5990
Fax: (507) 249-3149

Cedar Mountain Elementary
PO Box 38
Franklin, MN 55333
Phone: (507) 557-2251
Fax: (507) 557-2116

Over-the-Counter (OTC) Medication
Parent/Guardian Authorization Form

Parent/Guardian must complete and sign a form before school staff will give over-the-counter medications. Over-the-counter medications must be provided in the original labeled container. OTC medications will only be administered to a student according to the label directions, unless contrary written directions from a physician are provided.

Students in grades K-6 over the counters will need to be kept in health office.

***Students in grades 7-12 may possess and use nonprescription pain relief** in a manner consistent with the labeling, with written authorization from the parent/guardian permitting the student to self-administer the pain relief medication. The district may revoke a student's privilege to possess and use nonprescription pain relievers if the district determines that the student is abusing the privilege. This rule does not include any other over-the-counter medication, especially those possessing ephedrine or pseudoephedrine. (M.S. 121A.222)

Students may not share prescription or over-the-counter medications with any other student(s). Appropriate disciplinary action may be taken if necessary, upon the determination by the principal or his/her designee, after investigation that a violation of this policy has taken place.

STUDENT:____ **BIRTH DATE:**________________

SCHOOL NAME:____________________________________ **GRADE:**__________

Parent/Guardian Authorization

Medication	Dosage	Frequency	Duration (One Year)

Reason for Use:____
Allergies: (food or medications) ____Yes ____No Please List:______________________________________

This student is in grade 7-12 and I allow student to possess and self-administer the above pain reliever. ___Yes ___No

This student is both capable and responsible for self-administering this medication (subject to school policy):
____ No ____ Yes, supervised ____ Yes, unsupervised

- I request that the above medication be given at school per the above protocol.
- I release school personnel from any liability in the administration of this medication at school. I understand that medication will not necessarily be administered by a school nurse.
- I understand that to promote safety for my child, medication information may be shared with school personnel working with my child and with 911 personnel, if they are called.

My child needs medication on field trips. ___Yes ____No

Parent / Guardian Signature: (Required)__________________________________ **Date:**________________

Home Phone Number:____________________ Work:__________________________

Cell:__________________

*****Return this form to your school: ATTN: Cedar Mountain Schools: fax # CM Franklin 507-557-2116 or CM Morgan 507-249-5887**