STUDENT NAME: _____ **DATE OF BIRTH:** _____ **GRADE:** _____

Medical Alert/Health Conditions (Asthma, Allergies, etc.) ***Parents/Guardians are responsible for providing full details on any medical condition to the school.***

Medical Conditions: _____

Daily Medications: _____

ALLERGIES: _____

Do Allergies Require Emergency Medications? _____

By signing this document, I verify the above information (including health information) on this form is correct to the best of my knowledge including the address above being our place of residence
I understand that it is my responsibility to notify the school of any change in my address, phone number and/or my child's health information.

I authorize Chamberlain Public Schools to seek emergency medical treatment for my student if I cannot be reached in an emergency.

Parent Signature: _____ **Date:** _____

GRADES 6-12 ONLY

THIS FORM IS FOR NON-PRESCRIPTON OVER-THE-COUNTER MEDICATIONS. FOR ALL PRESCRIBED OVER-THE-COUNTER MEDICATION(S), PLEASE SEE THE NURSE. ***CHANGES CAN BE MADE BY CALLING BRIDGET STECKELBERG, RN, CHAMBERLAIN SCHOOL DISTRICT NURSE AT 605-234-4460***

COUGH DROPS:

I authorize my child to take over-the-counter/non-prescription cough drops while at school and relieve the school district and personnel of all responsibility. I understand that the school district and individuals involved will not be held liable for any adverse effects of the cough drops. I understand that my child shall possess only the number of cough drops necessary for school hours or the school event or activity for one day.

OVER-THE-COUNTER MEDICATIONS: ALL OVER-THE-COUNTER MEDICATIONS MUST BE IN THE APPROPRIATE LABLED CONTAINER! NO EXCEPTIONS!

Medication: _____ **Dose to be taken:** _____

Instructions: _____

Medication: _____ **Dose to be taken:** _____

Instructions: _____

I authorize my child to take the above over-the-counter/non-prescription medication (THIS DOES NOT INCLUDE CHEMICAL/HOMEOPATHIC SUBSTANCES AND COMPOUNDS, INCLUDING BUT NOT LIMITED TO NATURAL REMEDIES, HERBS AND VITAMINS) while at school and relieve the school district and personnel of all responsibilities. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. I understand that my child shall possess only the number of dose(s) necessary for school hours or school event or activity for one day.

ALL OVER-THE-COUNTER MEDICATIONS MUST BE IN THE APPROPRIATE LABLED BOTTLE. Students are prohibited from transferring, delivering or receiving any medications to or from another student. All violations will result in confiscation of the medication and subject student(s) to discipline in accordance with the District's progressive discipline policy. Students who use medication for purposes other than for its intended use will be disciplined and no longer be allowed to carry and self-administer medications.

Parent/Guardian: _____ **Date:** _____