**MENOMINEE INDIAN SCHOOL DISTRICT**

453.4 Exhibit (2)

OVER THE COUNTER MEDICATION PERMISSION SLIP

Student's Name:_______________ Date of Birth______Grade____

Parent/Guardian Name_______________________________________

Address____________________________________________________

Home Telephone_______________ Work Telephone_______________

Emergency contacts (Name/Telephone):

1.__________________________________________________________
2.__________________________________________________________

List any known ALLERGIES for student:______________________
___________________________________________________________

Please initial each after reading, then sign below:

_____ By signing below I am giving the Menominee Indian School District nursing personnel and/or designee permission to dispense over-the-counter medication to the student listed above as needed using his/her best judgment of the situation. If in doubt, nurse or designee may contact parent/guardian.

_____ I understand that over-the-counter medication will include but is not limited to: acetaminophen, ibuprofen, antacids, Sudafed, Pepto Bismol, cough syrup, antibiotic cream, hydrocortisone cream and Calamine lotion.

_____ I understand that this also includes the use of IPECAC SYRUP or CHARCOAL in the event of a poisoning (with instructions by the poison control center).

_____ I understand that this permission slip is valid for the __________ school year only.

_____I agree to report to the school nurse or designee any new allergies that may arise for the child listed above.

_____ I understand and agree that I am responsible for providing that school with any specific instructions regarding use of medicine and for providing the school with the necessary medications in such a case.

Parent/Guardian Signature_________________________ Date____

EXHIBIT APPROVED: September 1992

REVISED: July 2006