RIVERSIDE LOCAL SCHOOLS
NONPRESCRIBED MEDICATION OR TREATMENT (OCM)

Phone: 937-585-5981 Revised Date: August 15, 2011 Fax: 937-585-4599

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE NONPRESCRIBED MEDICATIONS AT SCHOOL AND ANY ACTIVITY, EVENT OR PROGRAM SPONSORED BY WHICH THE STUDENT'S SCHOOL IS A PRTICIPANT.

Student Information

Student Name:			Date of Birth:	
Student Address:				
School:	Grade/Class:	Teacher:	School Year:	
List any known drug allergies / reactions:			Height:	Weight:
Name of Medication:		Circumstance for use:		
Dosage:		Route:	Time/Interval:	
Date to begin medication:		Date to end medication:		
Circumstances for use:				
Special Instructions:				
Treatment in the event of an adverse reaction:				

Parent / Guardian Authorization

I am requesting permission for my child named above to:

☐ Use or receive the over-the-counter medication named above

(Check only one)

☐ Self-administer such medication in the presence of an authorized staff member.

☐ Keep the medication in his/her possession and self-administer the medication as needed.

I the Parent / Guardian understand the following (Check all boxes)

☐ As the Parent/Guardian I will assume responsibility for a safe delivery of the medication to the school.

☐ As the Parent/Guardian I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.

☐ As the Parent/Guardian I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

☐ I authorize an employee of the school board to administer the above medication.

☐ I understand that additional parent signed statements will be necessary if the dosage of medication is changed.

☐ I also authorize the license healthcare professional to talk with the parent to clarify medication order.

☐ Medication form must be received by the principal, his/her designee, and/or school nurse.

☐ I understand that the medication must be in the original container and be properly labeled with the student's name.

Parent / Guardian Signature:	Date:	#1 Contact Phone:	#2 Contact Phone:

Staff Authorization

The following staff members are authorized to administer the above non-prescribed medication / treatment.

_____	_____
_____	_____
_____	_____

Principal Signature:	Date:

ONE FORM FOR EACH MEDICATION GIVEN TO A STUDENT

FILE ACCORDING TO RIVERSIDE LOCAL SCHOOL DISTRICT POLICY