School District of Indian River County

6500 57th Street ● Vero Beach, Florida, 32967 ● Telephone: 772-564-3000 ● Fax: 772-564-3054

# Over the Counter (OTC) Medication for Headaches

School Year 20____ to 20 ____

Instructions: Please return this completed form to the school health room.

Student's Name_____

D.O.B._____ ID#_____

School Name_____ Grade_____

Students
Allergies_____

I grant permission to the principal or his/her designee to assist in the administration of this over-the-counter medication to relieve headaches, to my child while in school. I will supply the named medication in an unopened, original store-issued container. I understand that it is my responsibility to hand carry medication to the school health room. (DO NOT send medication to school with your child.) I understand that this agreement is valid until I terminate permission or until the end of the current school year. I understand that I will be notified when the medication is given. I understand that, according to F.S 1006.062, that there shall be no liability of civil damages as a result of the administration of the medication when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances.

Per HB 1537: This bill amends s. 1002.20, F.S., K-12 student and parent rights, to allow a student to possess and use a medication to relieve headaches while on school property or at a school-sponsored event or activity without a physician's note or prescription if the medication is regulated by the United States Food and Drug Administration for over-the-counter use to treat headache.

Medication Name: _____

Dosage: _____ Frequency: _____

Parent/Guardian Name (*print*) _____

Parent/Guardian (Signature required) _____ Date: _____

Home Phone #_____ Cell Phone #_____

RN Signature_____ Date_____