2025-2026 HLWW Middle School & High School
Over the Counter Medication Permission Form
Howard Lake-Waverly-Winsted School District #2687

Student's Name: _____ **Date of Birth:** _____

Medication name (mg/units/mL) _____

Dosage and amount (Tablets or liquid) _____

How is this medicine given? (Oral, topical, nasal, etc.) _____

How often (Example: Every 4 hours): _____

Is this a "PRN" meaning "as needed" medication? ☐ Yes ☐ No

Why is the student taking this? (Examples: headache, muscle aches, cramps, etc.)

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Parent/Guardian Permission for Medication Administration

- I am giving permission for HLWW school personnel to administer medication and release them from liability in the event of adverse reactions resulting in its use.
- I understand other designated staff may be consulted in regard to this medication usage to promote my child's safety. I agree to contact the district licensed school nurse if I do not want this information shared with other staff.
- I understand that I am responsible for arranging for an adult to transport medication to and from school.
- I understand the school district is an authorized entity to transport non-controlled substances for the purpose of destruction of unused or abandoned medications.
- My child's medication will be sent to school in an original, labeled container.

Parent/Guardian Signature: _____ Date: _____

Phone numbers where parent(s) can be reached: _____

Morgan Johnson, RN, District Licensed School Nurse
PO Box 708 Howard Lake, MN 55349
Cell: 763-290-3889 | Email: morgan.johnson@hlww.k12.mn.us
Health Office: 320-543-4600 Ext. 4501

Date medication was received:_____ Dropped off by:_____

Expiration Date: _____ No. of pills: _____ LSN/RN Review_____

Reviewed 8/2025 MJ