

Permission Form for Over-the-Counter Medication

Many times during the school year, a student may suffer from some minor pain or discomfort such as a headache, toothache, or minor skin irritation. With your consent, the school may give your child the medications for these minor complaints. You must understand that you are responsible for providing any medication(s) to the school in the original container for the school to dispense to your child. You are also responsible for registering any and all medications (prescription and non-prescription) in the school office. If an over-the-counter medication is needed for more than three (3) consecutive days, a medical physician will need to complete the prescribed medication form for the over-the-counter medication. Over-the-counter medication dosage will be given according to the container directions. A medical physician will need to complete the prescribed medication form if an over-the-counter medication dose needs to be altered.

Name of Student: _____ Allergies: _____

Grade: ___ Date of Birth ___ / ___ / ___ Phone # _____ - _____ - _____

Name of Parent/Guardian (please print): _____

Address: _____

I give permission for (name of child) _____ to receive the medications checked below according to standard school policy. I understand that I am to bring the medication to the school in the original container for the school to dispense. I also understand that I am to register this and all medications in the school office. I have initialed "Yes" by those medications to be administered to my child.

| Medication | | Initial "Yes" or "No" | |
|--------------------------|--|------------------------------|----------|
| Ibuprofen | (Example: Advil) | Yes _____ | No _____ |
| Acetaminophen | (Example: Tylenol) | Yes _____ | No _____ |
| Antacids | (Example: Roloids) | Yes _____ | No _____ |
| Cough Drops/Syrup | (Example: Robitussin) | Yes _____ | No _____ |
| Topical Creams/Lotions | (Example: Cortaid, Caldryl, Neosporin) | Yes _____ | No _____ |
| Sunburn Relief Spray | (Example: Medi-Quik) | Yes _____ | No _____ |
| Oral Pain Reliever | (Example: Orajel) | Yes _____ | No _____ |
| Decongestant | (Example: Sudafed) | Yes _____ | No _____ |
| Eye Wash | (Example: Collyrium / Saline Solution) | Yes _____ | No _____ |
| Anti-diarrhea Medication | (Example: Immodium A.D.) | Yes _____ | No _____ |
| Other | _____ | Yes _____ | No _____ |

Specific medical instructions on the condition and amount of medication to be administered:

I give permission for _____ to receive the above medication at school or on school

Student's Name

trips according to standard school policy and expressly hold harmless and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the physician's orders to be followed.

Date: _____ Signature: _____ Relationship: _____

Home Phone: _____ Work Phone _____ Emergency Phone _____