OVER THE COUNTER MEDICATION PERMISSION

This form is to be filled out by parent or legal guardian for students in Grades 6 – 12 ONLY

Over-the-counter medications will not be dispensed to students in grades PreK – Grade 5.

STUDENT'S NAME:_____ GRADE:_____

I give permission for the School Nurse to administer the following over-the-counter (OTC) medications to my child according to the established protocols. **I have crossed out and initialed any products that I do not wish my child to receive.** These products shall be used, Benadryl cream, Calamine/Caladryl lotion and triple antibiotic ointment as per the nursing procedures on file.

Acetaminophen (Tylenol)	Tablets - (grades 6 - 12 students) As needed for minor discomfort, headache, menstrual cramps, musculoskeletal pain, etc. *School Nurse may limit frequent administration of Tylenol.*
Benadryl	Liquid dosage for Emergency use only
Ibuprofen	Tablets - (12 years and older) As needed for menstrual cramps, minor discomfort, headache, musculoskeletal pain, dental pain, etc. *School Nurse may limit frequent administration of Ibuprofen.*
Tums (antacid)	As needed for minor gastric distress or indigestion.

All other medications require a written doctor's order and a written parental permission. Please contact the school nurse for additional information and the proper forms.

To the best of my knowledge, my child has no allergy/sensitivity to any of the above named products.

SIGNATURE OF PARENT/LEGAL GUARDIAN:_____ DATE:_____