School Supplied Over-the-Counter (OTC) Medications Permission Form

Student Name: _____ School Year: _____

Date of Birth: _____ Grade/Teacher: _____

The clinic will stock the following items to be dispensed as needed for minor complaints as indicated. With your consent, school personnel may give your child the medications if needed. A medication sheet must be filled out for each child and signed by a parent before any medication can be given.

All medications will be given according to dosage guidelines on the manufacturer's label.

Please initial each medication for which you are giving permission, and indicate whether or not you would like to be notified in the event that it is needed.

____ **Acetaminophen (Tylenol)**: as needed to relieve minor aches/pains due to headache, sore throat, toothache, muscular aches, menstrual cramps

I would like to be notified if my child receives this: ❑ yes ❑ no

____ **Ibuprofen (Motrin, Advil)**: as needed to relieve minor aches/pains due to headache, muscular aches, menstrual cramps, backache, toothache, sore throat

I would like to be notified if my child receives this: ❑ yes ❑ no

____ **Diphenhydramine (Benadryl)**: as needed to relieve symptoms due to hay fever or other respiratory allergies (sneezing, itching of nose/throat, runny nose, itchy/watery eyes)

I would like to be notified if my child receives this: ❑ yes ❑ no

____ **Antacid (Tums)**: as needed to relieve upset stomach, indigestion, heartburn

I would like to be notified if my child receives this: ❑ yes ❑ no

____ **Bismuth subsalicylate (Pepto-Bismol)**: as needed to relieve upset stomach, indigestion, heartburn, nausea, diarrhea

I would like to be notified if my child receives this: ❑ yes ❑ no

____ **Antibiotic ointment (Neosporin, bacitracin)**: as needed to prevent infection in minor cuts, scrapes, burns

I would like to be notified if my child receives this: ❑ yes ❑ no

____ **Anti-itch cream (hydrocortisone, Benadryl cream)**: as needed to relieve itching associated with minor skin irritations, inflammation, and rashes due to insect bites, eczema, etc.

I would like to be notified if my child receives this: ❑ yes ❑ no

____ **Vaseline**: as needed to relieve chapped lips or skin

I would like to be notified if my child receives this: ❑ yes ❑ no

____ **Cough drops**: as needed to relieve cough or throat irritation

I would like to be notified if my child receives this: ❑ yes ❑ no

I give permission for those indicated above to be given to my child as needed by school personnel according to guidelines on the manufacturer's label.

_____	_____	_____	_____
Parent/Guardian's Name (Print)	**Signature of Parent/Guardian**	**Date**	**Daytime Phone**