



OVER-THE-COUNTER MEDICATION PERMISSION FORM

I give permission for my child _____ to receive the following medications:

- ☐ Ibuprofen as needed for Pain/Fever over 100 degrees.
- ☐ Tylenol as needed for Pain/Fever over 100 degrees.
- ☐ Benadryl as needed for allergic reactions such as hives or rash.
- ☐ Hydrocortisone cream for itching related to hives or rash.
- ☐ Bacitracin (antibiotic ointment) for cuts or abrasions.
- ☐ Tums (antacid) as needed for an upset stomach.
- ☐ Other: _____

This medication will be administered by the school nurse and/or trained staff according to label directions. All medication administration will be reported to parents/guardians via email or phone in a timely manner.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

If you wish to be notified *PRIOR* to your child receiving an over the counter medication each time, please initial below. We will *not* be able to administer any of the above medications until we reach a parent/guardian if you initial this line.

Parent/Guardian Initial: _____