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: ____________