Authorization for Nonprescription Medication or Treatment

To the Parent:
The following information is necessary for any student to use nonprescription medications in school. All spaces must be completed.

____
Student Name | Date of Birth | Weight | School

____
Grade | Medication Allergies

____
Medications Taken at Home

A: PLEASE INITIAL EACH MEDICATION FOR WHICH YOU ARE GIVING PERMISSION

________ I approve all medications listed below.

________ I do not want any nonprescription medications given to my student.

Topical:
_____ Antibiotic cream (i.e. Bacitracin, Neosporin)
_____ Caladryl lotion
_____ Hydrocortisone cream 1%
_____ Benadryl Cream 2%
_____ Sunscreen
_____ Oragel(20%benzocaine)
_____ First Aid ointment (5% benzocaine/antiseptic)
_____ Eye drops for dryness (Refresh)

Oral:
_____ Ibuprofen (Advil, Motrin)
_____ Acetominophen (Tylenol)
_____ Antacid (Mylanta, Maalox, Tums)
_____ Cold Medication (Guaifenesin, Tylenol, dextromethorphan, phenylephrine)*
_____ Antihistamine (Benadryl, Loratadine*, Cetirizine*)
_____ Cramp Tab (tylenol, pamabrom)*
_____ Migraine Formula (Tylenol, Aspirin, Caffeine) for migraines*
_____ Dairy Relief(Lactaid)*
_____ Loperamide (Immodium)*
_____ Famotidine 20mg.(Pepcid)*
_____ Motion Sickness (meclizine)*
_____ Cough Drops (menthol)*
**Available only at the secondary level*

The Medications Indicated Above May Be Administered to My Student

______________________________________ ____________________
Signature of Parent/Guardian | Date

Nonprescription medications will be given at the recommended package dosage and directions by the School Nurse/ Registered Nurse/Designated Staff. The school is not able to supply medication for frequent or daily use.

For nonprescription medications not listed on this form, or if the medication must be given frequently, please use the area below.

B. I am requesting permission for my child named above to use or receive the following over-the-counter medication(s):

Medication Dosage

Initial option below:

____ Have medication(s) administered by a Designated District Employee.
____ Self Administer such medication(s) in the presence of a Designated District Employee.
____ Keep the medication(s) in his/her possession and self administer the medication(s) as needed.

C. I will assume responsibility for safe delivery of the medication to school in its original container.
D. I will notify the school immediately if there is any change in the use of the medication or treatment.
E. Our physician has instructed that this medication should be administered in the above-designated dosage.
F. I release and agree to hold the Board, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.
G. I will call the school nurse and send a written note if my student is taken off this medication. I will retrieve the medication within three (3) days. I understand the medication will be disposed of after three days.

Parent/Guardian Signature Date Phone Number