"OVER-THE-COUNTER" MEDICATION FORM

STUDENT'S NAME ____ DATE ______________________

GRADUATING CLASS ____

MEDICATION ALLERGIES ____

List other medications your child receives regularly ________________________________

Please check any medications you wish to be made available to your child during school:

For headaches/fever/cramps/muscle aches:

( ) **Acetaminophen** (like Tylenol) 1 or 2 - 500 mg tabs every 4-6 hours
( ) **Ibuprofen** (like Advil, Motrin) 1 or 2 – 200mg tabs every 6-8 hours

For mild cold symptoms:

( ) **Cough drops** 1 or 2 as needed

For mild stomach discomfort:

( ) **Antacid** (Tums or generic equivalent) 2 tabs as needed

For mild skin irritation or first aid treatment:

( ) **Antibiotic ointment** (like Bacitracin, Polysporin)

( ) I DO NOT WANT ANY MEDICATION GIVEN TO MY CHILD IN SCHOOL

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TO BE COMPLETED BY PARENT/GUARDIAN:
I assure that my child ____ has been given the above checked medications previously without adverse effects.
I give my permission for the school designee to administer the above checked medications, as prescribed, to my child as named above. I understand that generic equivalent medications may be used.

Parent signature ____ Date ____________________

Physician's (APN, PA) Name Printed ____
Office Address and Phone Number ____

The physician/pharmacist may be contacted by the school nurse with questions related to the student's other medications (if applicable).