Parental Permission for Occasional Use of Over-the-Counter Medication Only

Student Name_____ Age/Grade_____

The School Office has a LIMITED SUPPLY of the over-the-counter medications that can be dispensed with written parental permission by the School Office. Students requesting medication or in need will be evaluated for treatment of minor aches or pains or discomfort due to the common cold, headache, toothache or menstrual cramps. The School Office will notify the parent/guardian when medication is needed, to discuss the frequency of your child's need for medication and/or to recommend follow-up care with your health-care provider. Acetaminophen and ibuprofen will be limited to 3 doses in 1 month's time. Any additional or increased usage will require a doctor's and parent's signature on a "Permission for Medication Administration" form along with the student's own supply.

For any known chronic or frequent condition requiring regular administration of the medications listed here, or for any other over-the-counter medication not listed (such as eye drops, etc.) a "Permissions for Medication Administration" form must be completed and signed by the parent/guardian, along with sending the student's own supply of the medication. Medication must be in its original container and properly labeled.

_____, I give permission for the School Office or other school staff designated by the principal to administer the medication(s) checked. I certify that my child has been given at least one dose of any/all medications I have checked and there was no adverse reaction from it. I also understand that any designated school employee who administers this medication to my child in accordance with labeled instructions shall not be liable for damages as a result of an adverse drug reaction suffered by the pupil or because of a mislabeled or altered product.

_____, I prefer to send my child's own supply of the medications listed below:

Check all that apply. Cross out any that should not be allowed.

_____ Acetaminophen (generic Tylenol) per label directions

_____ Ibuprofen (generic Advil, Motrin) perlabel directions

_____ Antibiotic Ointment (minor cuts/scrapes)

_____ Cough drops

_____ Anti-itch lotion (calamine/caladryl)

_____ _____

Signature of Parent/Guardian Date