PARENT PERMISSION TO GIVE "OCCASIONAL" OVER-THE-COUNTER MEDICATION

Student Name ___________________________ Grade ______ School Year: ______________________

Over-the-counter (OTC) medications are drugs that do not require a prescription and are purchased "over-the-counter." This form is required before over-the-counter medications can be administered at school.

Parents and Physicians: PLEASE INITIAL EACH MEDICATION FOR WHICH YOU ARE GIVING PERMISSION .
Only medications initialed by both the parent and physician will be administered at school.

Student Complaint	**Medication**	**Parent's Initials**	**Physician's Initials**
Headache and/or fever	Acetaminophen or Ibuprofen		
Discomfort	Acetaminophen or Ibuprofen		
Menstrual Difficulties	Acetaminophen or Ibuprofen		
Itching or discomfort	Diphendydramine Cream, Calamine Lotion, or 1% hydrocortisone cream		
Burns	Aloe Vera Gel or other burn gel		
Severe allergic reaction: Possible Anaphylaxis	Diphenhydramine		
Insect Stings/ Bites	Sting relief wipes		
Cuts & Scrapes	Antibiotic Cream		

PhysicianComments/Concernes:____
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I hereby authorize the school nurse and trained school staff to administer over the counter medication to my child as prescribed by standing orders as indicated above. I understand that if my child visits the nurse multiple times with the same complaint, I will be contacted, and my child will be referred to his/her medical provider for evaluation. If any adverse reaction to medication is noted, I will be notified immediately. In case of severe reaction, I give permission for my child to receive emergency care. I hereby release the school and its staff from any and all liability that may result from my child taking medication. This permission form is valid for the ____________________ school year only.

____Date:_____ ___________________

Signature of Parent or Guardian

____ Date:_________________________

Signature of Physician