Permission Form for Over-the-Counter Medication

Many times during the school year, a student may suffer from some minor pain or discomfort such as a headache, toothache, or minor skin irritation. With your consent, the school may give your child the medications for these minor complaints. You must understand that you are responsible for providing any medication(s) to the school in the original container for the school to dispense to your child. You are also responsible for registering any and all medications (prescription and non-prescription) in the school office. If an over-the-counter medication is needed for more than three (3) consecutive days, a medical physician will need to complete the prescribed medication form for the over-the-counter medication. Over-the-counter medication dosage will be given according to the container directions. A medical physician will need to complete the prescribed medication form if an over-the-counter medication dose needs to be altered.

Name of Student: ______________________ Allergies: ______________

Grade: ___ Date of Birth ______/______/______ Phone # ______-______-______

Name of Parent/Guardian (please print): ________________________________

Address: ____

I give permission for (name of child) ______________________ to receive the medications checked below according to standard school policy. I understand that I am to bring the medication to the school in the original container for the school to dispense. I also understand that I am to register this and all medications in the school office. I have initialed "Yes" by those medications to be administered to my child.

Medication		Initial "Yes" or "No"
Ibuprofen	(Example: Advil)	Yes______ No______
Acetaminophen	(Example: Tylenol)	Yes______ No______
Antacids	(Example: Rolaids)	Yes______ No______
Cough Drops/Syrup	(Example: Robitussin)	Yes______ No______
Topical Creams/Lotions	(Example: Cortaid, Caldryl, Neosporin)	Yes______ No______
Sunburn Relief Spray	(Example: Medi-Quik)	Yes______ No______
Oral Pain Reliever	(Example: Orajel)	Yes______ No______
Decongestant	(Example: Sudafed)	Yes______ No______
Eye Wash	(Example: Collyrium / Saline Solution)	Yes______ No______
Anti-diarrhea Medication	(Example: Immodium A.D.)	Yes______ No______
Other	______________	Yes______ No______

Specific medical instructions on the condition and amount of medication to be administered:

____

I give permission for ______________________ to receive the above medication at school or on school
Student's Name
trips according to standard school policy and expressly hold harmless and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the physician's orders to be followed.

Date: ________ *Signature:* ______________________ *Relationship:* ____________

Home Phone: ____________ *Work Phone* ____________ *Emergency Phone* ____________