OVER-THE-COUNTER MEDICATION PERMISSION

This form is to be filled out by parent or legal guardian for students in Grades 6 – 12 ONLY

Over-the-counter medications will not be dispensed to students in grades PreK – Grade 5.

STUDENT'S NAME:____ GRADE:___________

I give permission for the School Nurse to administer the following over-the-counter (OTC) medications to my child according to the established protocols. **I have crossed out and initialed any products that I do not wish my child to receive.**

Acetaminophen (Tylenol)	Tablets - (grades 6 - 12 students) As needed for minor discomfort, headache, menstrual cramps, musculoskeletal pain, etc. *School Nurse may limit frequent administration of Tylenol.*
Benadryl	Liquid (6 yrs. and older) As needed for local allergic reaction
Benadryl cream	As needed for minor skin irritation, itchy rash, insect bite, etc.
Calamine/Caladryl lotion	As needed for minor skin irritation, itchy rash, insect bite, etc.
Ibuprofen	Tablets - (12 years and older) As needed for menstrual cramps, minor discomfort, headache, musculoskeletal pain, dental pain, etc. *School Nurse may limit frequent administration of Ibuprofen.*
Tums (antacid)	As needed for minor gastric distress or indigestion.
Triple antibiotic ointment	As needed for cuts, scrapes, etc.

All other medications require a written doctor's order and a written parental permission. Please contact the school nurse for additional information and the proper forms.

To the best of my knowledge, my child has no allergy/sensitivity to any of the above named products.

SIGNATURE OF PARENT/LEGAL GUARDIAN:____ DATE:________________