PARENT PERMISSION TO GIVE “OCCASIONAL” OVER-THE-COUNTER MEDICATION

Student Name ___________________________ School________________________ Grade ______

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. Exceptions to this are homeopathic/herbal medications and aspirin, which require completing the form “Permission to Give Prescription/Homeopathic Medication at School.”

PLEASE INITIAL EACH MEDICATION FOR WHICH YOU ARE GIVING PERMISSION

____  I approve all medications listed below
____  I do not want any OTC meds given to my student ORAL

Antibiotic cream (i.e. Bacitracin Cream, Polysporin)
Hydrocortisone cream (i.e. Cortaid)
Benadryl Cream (i.e. Caladryl, Diphenhydramine)
Sunscreen
Ointment products containing benzocaine (oragel, chloraseptic)
Tincture of Benzoin, Mastisol (helps tape adhere)
Burn gels
Eye drops for dryness
Ibuprofen (i.e. Advil, Motrin, Nuprin)
Acetaminophen (i.e. Tylenol)
Antacid (i.e. Mylanta, Maalox, Tums)
Cold Medications (guaifenesin, pseudoephedrine - phenylephrine)
Antihistamine (i.e. Benadryl, chlorpheniramine, Loratadine)
Cough syrup (dextromethorphan, plain or medicated cough drops)

Please check with the school nurse to see which medications are available for students in the school clinic and which medications you will need to supply. OTC medications will be given at the manufacturer’s recommended dosage.

When sending OTC medications to school, they must be in the original manufacturer’s container with the label intact or the medication will not be accepted. For safety reasons, parents are requested to bring the medication directly to the nurse. The medication should be sealed in an envelope in the original manufacturer’s container. The school is not able to supply medication for frequent or daily use.

For OTC medications not listed on this form, or if the medication must be given daily, please use the form “Permission to Give Over-the-Counter Medication at School.”

MEDICATION HISTORY:
Is your student allergic to any medications? _____ If yes, please list medicine(s) and type of reaction:
__________________________________________________________________________________________________________________________

Does your student take any medication (either over-the-counter or prescription) on a regular basis? _____

If yes, please list: _______________________________________________________________________________________________

Parent Name – Printed ____________________________________________

Parent Name – Signature __________________________________________ Date __________________________