



Consent to Treatment and Over-the-Counter Medication Form

We/I consent for the DePaul College Prep school nurse and/or appropriate school personnel to treat our/my child _____ (name/s) if judged as a medical, psychological, surgical, dental, or other emergency illness, injury or any other conditions. If my child develops minor symptoms during school hours that may not be relieved through comfort care and non-pharmaceutical interventions, the school's nurse has the authorization to administer the following over the counter medications to my child:

Please check the boxes that you authorize for your child

- Loperamide/Antidiarrheal (Diamode) 2mg
- Calcium carbonate/Antacid (Ban-acid) 750mg
- Acetaminophen/Non-Aspirin (Apap) 500mg
- NSAIDS (Aspirin) 325mg
- Menthol (Cough Drops) 7.6mg
- Anti-inflammatory/Pain reliever (Ibuprofen)
- Antihistamine/Diphenhydramine (Diphen) 25mg
- Bacitracin zinc/Neomycin Sulfate/Polymyx-B Sulfate (Triple Antibiotic)
- Saline eye rinse

We/I have verified with my child's physician/pharmacist that he/she/they are safe to take these medications. If we/I cannot be immediately contacted for an immediate medical event our child has been affected by, we/I authorize the DePaul College Prep school nurse and/or appropriate school personnel to contact emergency services and perform emergency care judged appropriate.

_____	_____
Student Name	Date of Birth
_____	_____
Student #2 Name	Date of Birth
_____	_____
Parent/Guardian Printed name	Date
_____	_____
Parent/Guardian Signature	Date