



UNIVERSITY OF DETROIT JESUIT

HIGH SCHOOL AND ACADEMY

Over-the-Counter Medication Form

University of Detroit Jesuit High School and Academy recognizes its responsibility to its students, especially in times of an emergency. The school retains a health professional who is available for the care of students during school hours in the case of unexpected, non-chronic illness or injury. In the event that immediate medical attention of a true emergent nature is necessary, and one or both parents or a legal guardian cannot be immediately contacted, authorities of University of Detroit Jesuit High School are authorized to proceed with contacting emergency services and seeking emergency care as deemed appropriate.

It is recognized that minor symptoms may be experienced during the school day for which a student may present to the Student Affairs Office (SAO) seeking assistance. Given a student is not allowed to be in possession of any medication on school grounds, the School Health Professional/SAO does have certain over-the-counter medications in stock which can be administered if authorized by the parent/legal guardian.

Before granting school permission to administer over-the-counter medication, please check with your doctor/pharmacist that the medications below do not interact with any medications your son may already be taking.

Student's Last Name	First Name	DOB	Grade
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_____ **No**, my son **may not be given** any over-the-counter medications or options listed below. We/I understand that only comfort care measures (such as an ice pack) will be administered until I am contacted.

_____ **Yes**, my son **may receive** the over-the-counter medications indicated below if deemed appropriate based on his presentation/symptoms. I have checked with his physician/pharmacist as to verify the safety with his other medication.

- ___ Acetaminophen (Tylenol) 325mg tablets (1 or 2)
- ___ Ibuprofen (Motrin/Advil) 200mg tablets (1 or 2)
- ___ Benadryl antihistamine (for generalized allergic reaction) 25mg
- ___ Tums antacid

Parents/Guardians will be notified via email or phone call if the above checked medication(s) are administered.

Parent/Guardian Signature _____ Date _____