Calvary Day School
Over-The-Counter Medication Form

Student Name: ____

Birth Date: _________________ Grade:______________

THIS BOX TO BE COMPLETED BY THE PARENT/GUARDIAN

<table>
<tr>
<td>
<u>Pain</u>:
❏ Acetaminophen (Tylenol or generic equivalent)
❏ Ibuprofen (Advil or generic equivalent)
❏ Midol (Girls only)
<u>Bee Stings or Allergic Reactions</u>:
❏ Diphenhydramine (Benadryl or generic equivalent)
<u>First Aid for Minor Scrapes/Itching:</u>
❏ Topical Antibiotic Cream (Polysporin or generic equivalent)
❏ Hydrocortisone Cream
<u>Other</u>:
❏ Check here for OTC medication not listed
Medication Name:______________________
❏ Check here for permission for ALL over-the-counter medications listed
</td>
<td>
*Medications will be administered and dosed according to product directions and the child's weight.

Child’s Weight ___________(required)
</td>
</tr>
</table>

PARENT’S PERMISSION

I do hereby give permission for the above indicated non-prescription medications to be administered to my child (named above) by the Calvary Day School school nurse or designee. I do hereby release Calvary Day School its administrators, staff and faculty from any and all damages for any accident, injury or illness that may result from or related to the administration of the above indicated non-prescription medications. I hereby authorize the school nurse to share this information with Calvary Day School staff as necessary for the safety and welfare of my child during the school year.

_______________________________________ ____________________

PARENT/GUARDIAN SIGNATURE **DATE**