St. Patrick's Episcopal Day School
Over-the-Counter Medication Permission Form

Health Office Phone: 202-342-2820 | School Fax: 202-342-7001

Student Name_____ Grade_____ Date of Birth_____

Medication Allergies _____

PLEASE SIGN UNDER ONLY "OPTION A" OR "OPTION B"

OPTION A

I authorize the St. Patrick's School Nurse and non-medical faculty/staff (overnight field trips only) to administer the below-marked over-the-counter (OTC) medications, if needed, to my child. OTC medications are administered per package directions unless written directives are provided by a physician/health care practitioner.

___ Acetaminophen (Tylenol)

___ Ibuprofen (Advil, Motrin)

___ Diphenhydramine HCL (Benadryl)

___ Topical Antibiotic Ointment

___ Antacid (Tums)

___ Throat Lozenge

___ Aloe Vera Gel

___ Anti-itch cream (Caladryl)

Please list any other OTC medication(s) that may be administered by the School Nurse. The parent will be responsible for supplying this medication.

Medication(s):_____

Parent/Guardian and Healthcare Provider signatures required

*Parent/Guardian Signature: _____ Date: _____

*Health Care Provider Signature: _____ Date: _____

(OR) OPTION B

I do not authorize the School Nurse to administer any over-the-counter (OTC) medications to my child.

Parent/Guardian Signature: _____ Date:_____

I acknowledge there are risks to taking any medication. I agree St. Patrick's Episcopal Day School, its officers, and its employees shall incur no liability and shall be held harmless against any claims that may arise relating to the administration of medication to my child. I understand it is my responsibility to notify St. Patrick's of any changes or additions to the information provided on this form.