Over-the Counter Medication Authorization Form *This form is to be used for School Health Office stocked over-the-counter (OTC) medications only.*		**March 2014** **Revised: Feb 2018**

Duplin County Schools Medical Advisor has provided standing orders and protocols for over-the-counter medications listed below. With a signed consent from a parent or guardian, the students may now receive these over-the-counter medications to relieve their symptoms and allow them to have a successful school day without you having to get an order from their primary care physician. If you would like your child to receive these medications at school, please indicate your preferences below and sign your consent. The school nurse will assess your child and appropriate comfort measures may be utilized before medication is administered. Medications may be added or deleted from this authorization form at any time during the school year by contacting the School Nurse. This form must be completed in full each school year by a parent or guardian.

Part 1 To be completed by parent or guardian

Student Name: ______________________ DOB: ______________ School year: ____________

Drug Allergies: ____________________________ Grade: ______ Homeroom: ______________

Medical Condition/s: ____

List ALL medications your child takes daily or occasionally: ______________________________

Part 2 To be completed by parent or guardian

- *I hereby authorize the school nurse to administer the over-the-counter medications* ***checked below.***
- *I understand these medications will be given only after it has been determined it is appropriate and necessary.*
- *I understand that the use of* ***ibuprofen*** *and* ***acetaminophen*** *is limited to* ***three doses in one month*** *and a doctor's evaluation and medication order will be required if my child needs to take analgesics more frequently.*

Yes___ No___	**Acetaminophen** – administer the dosage based on age and weight of child
Yes___ No___	**Ibuprofen** – administer the dosage based on age and weight of child
Yes___ No___	**Tums** – administer according to manufacturer's label
Yes___ No ___	**Hydrocortisone cream** – for insect bites or rash
Yes___ No___	**Antibiotic ointment** – for cuts or scrapes
Yes___ No___	**Cough drops** – for cough or throat irritation

Parent/Guardian Name (printed): **Daytime phone:**

Signature: **Date:**

Part 3 To be completed by School Nurse

Parts 1 and 2 above are complete including signatures.

School Nurse Signature: **Date:**

Date	*Time*	*Reason or Complaint*	*Medication*	*Dose*	*Nurse's Initials*