Sault Ste. Marie Public Schools
Authorization form for Over the Counter
Medications approved by physician & parent/legal guardian

Student's name:_____ School:_____
Birth date: ____/____/_____ Name of Physician_____

Please check box of what you approve
Following directions as indicated on box or bottle for age & or weight

Headache,fever or pain
Children's Tylenol or ibuprofen or Midol

Upset stomach
Children's Pepto Bismul/Tums/Rolaids

Allergy
(sneezing, watery eyes, runny nose,itchy throat) Benadryl (diphenhydramine HCL 25 mg)

Cough or sore throat
Cough drops

Diarrhea/loose stools
Anti-diarrheal (loperamide HCL 2mg)
Not for 6 year olds and younger or under 47 pounds.

Eye drops
For eye debris or irritation

Rash or itchy skin
Wash, dry, apply skin lotion if dry skin or hydrocortisone cream if itchy, or Vaseline or petroleum jelly to soothe an abrasion once clean.

Mouth & or lips Medication
Canker sore medication
lip balm

Physician / Nurse Practitioner signature: _____

Parent / Legal Guardian signature: _____

Physician Permission to self carry if SAHS student _____