

Black Hawk School District

CONSENT for Over-the-Counter (OTC)/Non-Prescription Medication Administration Authorization

Please complete *both* sections

STUDENT NAME: _____ BIRTHDATE: _____

GRADE: _____

*This form will need to be completed **annually**. It will be kept on file in the school health office. If there is not a form signed, a phone call to a parent/guardian on one occasion will be made. The form will then be sent home to be signed and returned. Acetaminophen, Ibuprofen, Benadryl, and Tums will be available. If you prefer, you may send a separate original labeled bottle for your child.

FOR COMPLETION BY PARENT/GUARDIAN

Please initial each medication you give permission for administration at school. Circle the preferred form of medication.

_____ **Ibuprofen (Advil)** (for pain, fever) Liquid Chewables Tablets

_____ **Acetaminophen (Tylenol)** (for pain, fever) Liquid Chewables Tablets

_____ **Benadryl** (for allergic reaction, itching) Liquid Tablets

_____ **Tums (Regular Strength)**

___ I give permission for the above medication(s) to be given as directed

Qualified persons trained in medication administration have my permission to administer the above medications as directed on the label.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Home Phone: _____ Work Phone: _____

