

# Lumberton ISD Over-The-Counter

## Non-Prescription Medication Release Form

Release form allows Lumberton Independent School District school nurses to release Over-The-Counter (OTC) medications as listed below to students should they request it while at school. The parent/guardian must sign this form in the appropriate space provided to indicate medication release approval. A signed release form must be on file in the school clinic for OTCs to be dispensed.

To be completed by parent/guardian: ALLERGIES: \_\_\_\_\_ HEIGHT: \_\_\_\_\_

Please print Student's Name:	DOB/Grade:
Please print Parent/Guardian's Name:	Date:
Parent/Guardian's Signature: *	Phone Number:

Initial Authorizing Administration	Medication Name	Form of Dosage	Indication
	ACETAMINOPHEN (Tylenol)	LIQUID (FLAVORED) 160 mg/5 ml	PAIN/FEVER
	ACETAMINOPHEN (Tylenol)	325 MG TABLET	PAIN/FEVER
	BISMATROL (Pepto-Bismol)	LIQUID	UPSET STOMACH/NAUSEA/INDIGESTION
	BISMATROL (Pepto-Bismol)	TABLETS	UPSET STOMACH/NAUSEA/INDIGESTION
	CALCIUM ANTACID (Tums)	TABLETS	ACID INDEGESTION/UPSET STOMACH/ HEARTBURN
	COUGH DROPS	DROPS	COUGH/THROAT IRRITATION
	DIPHENHYDRAMINE (Benadryl)	LIQUID (FLAVORED) 12.5 mg/5 ml	ALLERGY/ANTIHISTAMINE
	DIPHENHYDRAMINE (Benadryl)	TABLETS/CAPSULE 25 mg	ALLERGY/ANTIHISTAMINE
	IBUPROFEN (Advil/Motrin)	LIQUID (FLAVORED) 100 mg/5 ml	PAIN/FEVER
	IBUPROFEN (Advil/Motrin)	TABLETS 200 MG	PAIN/FEVER
	CETIRIZINE/ZYRTEC	LIQUID 1MG/ML	ALLERGY/ANTIHISTAMINE
	CETIRIZINE/ZYRTEC	TABLETS/CHEWABLE 5MG OR 10MG	ALLERGY/ANTIHISTAMINE

OTHER: \_\_\_\_\_

**All OTC medication will be administered to students per age, weight, and package directions.**

\* Parent/guardian signature above indicates that I have reviewed the medications and forms of dosage to be administered to my student as indicated by my initials and agree to the accuracy of this form, and for XXXXXX Independent School District school nurse to administer these OTC medications to my student.

## Request for Medication Administration

Student: \_\_\_\_\_ DOB \_\_\_\_\_ Grade: \_\_\_\_\_ Campus: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Take medication:  by mouth  via inhaler  topical (cream)  injection  other \_\_\_\_\_

Condition for which medication is given: \_\_\_\_\_

To be given:  Entire School Year - or -  The following dates: \_\_\_/\_\_\_/\_\_\_ to: \_\_\_/\_\_\_/\_\_\_

When:  At the following time(s): \_\_\_\_\_ - or -  As needed every \_\_\_\_\_ hours Special considerations/side effects: \_\_\_\_\_

For Daily Medications: \_\_\_\_\_ Yes, please send on field trips  
 \_\_\_\_\_ No, please do not send on field trips

Other medications taken at home: \_\_\_\_\_

List any food or drug allergies: \_\_\_\_\_

- prescription medication
- any over-the-counter medication

**Must be signed by a physician for any of these reasons:**

<p><b>Parent/Guardian:</b> I give permission for district personnel to administer medication to my child in accordance with Texas Education Agency and District policies. I also acknowledge that it is the parent/guardian responsibility to maintain medication supply. Unclaimed medication will be destroyed at the end of the school year.</p>	
Signature:	Date:
Printed Name:	Phone:

<p><b>Physician:</b> I request that the student receive this medication during the school day as instructed above.</p>	
Signature:	Date:
Printed Name:	Phone:

<p><b>School:</b> Medication was received by:</p>		
Signature:	Date:	Quantity Received:
Printed Name:	Phone Ext.:	Expiration Date: