SPASH

PARENT PERMISSION FOR THE ADMINISTRATION OF OVER-THE-COUNTER MEDICATION

_____School Year

Student Last Name _____First Name _____ Grade____

I give my permission for the school nurse or trained staff to administer the following medication(s) on an as needed basis to my son/daughter: *Parent/Guardian of students with asthma or other chronic illnesses should consult with their health care provider before signing permission for these over-the-counter medications.*

_____

(Please check all that apply):

____ **Acetaminophen (Tylenol)** 325 mg, tablet, 1-2 every 4-6 hours

____ **Ibuprofen (Motrin)** 200 mg, tablet, 1-2 every 4-6 hours

____ **Diphenhydramine/Benadryl** 25 mg tablet, 1 tablet every 6 hours

____ **Throat lozenge**, 1-2 every 4 hours

_____ **Calcium Carbonate (Tums)** 500 mg tablet, chew 2-4 tablets, may repeat hourly X 2. Not to exceed 8 tablets in 8 hour period

Dosages greater than listed above, will only be given with a signed order from the student's physician. Students who take OTC medication daily for more than 7 days will need a physician's order to continue taking OTC medication on a daily basis.

For the following conditions: (Check all that apply)

____ Headache ____ Common Cold Symptoms ____ Mild Musculoskeletal Pain ____ Sore Throat
____ Menstrual Cramps ____ Stomach ache____ Itching _____ Hives _____ Rash

Other (please describe) _____

Parent/Guardian Signature _____Date _____

Phone Number (Home/work/cell) _____

Student’s Name ______________________________________ Grade________

Check ( ) if Parent Permission:

Approved Medication	**Medication**	**Dosage**	**Code**
	Acetaminophen	325 mg; 1-2 tabs q 4-6 hours	ACT
	Ibuprofen	200 mg; 1-2 tabs q 4-6 hours	IBU
	*Diphenhydramine/Benadryl	25 mg; 1 tab q 6 hours	BEN
	Throat Lozenges	1-2 lozenges every 4 hours	LOZ
	Calcium Carbonate (TUMS)	500 mg; 2-4 tabs q hour x2	CAL

*Notify parent when and why medication was administered

STAFF DISPENSING MEDICATION

Initials	Signature

Date	Time	Med Code	Initials	Date	Time	Med Code	Initials