

St. Patrick's Episcopal Day School

Over-the-Counter Medication Permission Form

Health Office Phone: 202-342-2820

Student Name _____ Grade _____

Date of Birth _____ Medication Allergies _____

PLEASE CHOOSE EITHER "OPTION A" OR "OPTION B"

OPTION A

I authorize the St. Patrick's School Nurse to administer the below-marked over-the-counter (OTC) medications, if needed, to my child.

___ Acetaminophen (Tylenol) ___ Antacid (Tums) ___ Ibuprofen (Advil, Motrin)

___ Throat Lozenge ___ Diphenhydramine HCL (Benadryl) ___ Aloe Vera Gel

___ Topical Antibiotic Ointment ___ Anti-itch cream (Caladryl) ___ Eye Wash

Please list any other OTC medication(s) that may be administered by the School Nurse. This includes, but not limited to, any OTC allergy and cough medications, Lactaid and sunscreen since the Health Office does not carry these medications. Parents/Guardians will be responsible for supplying this medication.

Medication(s): _____

***Parent/Guardian and Healthcare Provider signatures required**

➡ *Parent/Guardian Signature: _____ Date: _____

➡ *Health Care Provider Signature: _____ Date: _____

(OR) OPTION B

I do not authorize the School Nurse to administer any over-the-counter (OTC) medications to my child.

➡ *Parent/Guardian Signature: _____ Date: _____

I acknowledge there are risks to taking any medication. I agree St. Patrick's Episcopal Day School, its officers, and its employees shall incur no liability and shall be held harmless against any claims that may arise relating to the administration of medication to my child. I understand it is my responsibility to notify St. Patrick's of any changes or additions to the information provided on this form.