Marietta city schools
A Georgia Charter System

Assistance With Over The Counter Stock Medications

The following OTC medications/items have been approved by our school physician and may be administered for symptomatic relief of minor health conditions at the discretion of the clinic nurse and with parent authorization. Please print, sign, and return this form at the beginning of the school year.

Student Name:_____ Grade/Homeroom:_____

Date of Birth/Age:_____ Student's weight:_____

School _____Year:_____

I authorize for the clinic nurse to administer the following over the counter medications/items as needed based on best evidence and product directions **(check all that you authorize):**

- Acetaminophen for pain
- Ibuprofen for pain and/or inflammation
- Antacid tablets-for minor gastrointestinal discomfort
- Bacitracin- for minor cuts and abrasions
- Hydrocortisone ointment or Cream-for minor skin irritation
- Anti-itch creams/lotions (ie.calamine, calamine clear)- for minor skin irritation

The following items ***will be used*** on a regular basis in the clinic to help treat minor complaints. Please communicate with your child's school nurse if you do not want your child to have these items used.

> Antiseptic soaps/wipes/sprays, body lotion/creams/balms, eye care solutions (ie contact solution, rewetting drops), petroleum jelly/aquaphor, saline wound wash, salt water gargle, sting kill wipes, aloe, toothpaste, mouthwash, baby wipes, dental wax

****I authorize the personnel of Marietta City Schools to assist my child in taking medication. I hereby release and waive, and further agree to indemnify, hold harmless or reimburse Marietta City Schools, the individual members, agents, employees and representatives thereof, from and against, any claim which I, any other parent or guardian, any sibling, the student, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, for any losses, damages or injuries arising out of, during or in connection with the administering of this medication*.

Signature of parent/guardian_____ Date_____