



Calvary Day School Over-The-Counter Medication Form

Student Name: _____ Birth Date: _____ Grade: _____

* In accordance with North Carolina State Law NC 115C-375.1, **physician authorization and parent permission** are required before school employees can administer any OTC medication.

THIS BOX TO BE COMPLETED BY THE PARENTS/GUARDIAN

<p>Pain:</p> <p><input type="checkbox"/> Acetaminophen (Tylenol or generic equivalent)</p> <p><input type="checkbox"/> Ibuprofen (Advil or generic equivalent)</p> <p><input type="checkbox"/> Midol (Girls only)</p> <p>Bee Stings or Allergic Reactions:</p> <p><input type="checkbox"/> Diphenhydramine (Benadryl or generic equivalent)</p> <p>Cough Suppressants:</p> <p><input type="checkbox"/> Dextromethorphan (Delsym, Robitussin, etc.)</p> <p><input type="checkbox"/> Cough Drops</p>	<p>First Aid for Minor Scrapes/Itching:</p> <p><input type="checkbox"/> Topical Antibiotic Cream (Polysporin or generic equivalent)</p> <p><input type="checkbox"/> Hydrocortisone Cream</p> <p>Antacids:</p> <p><input type="checkbox"/> Tums Chewable tablets</p> <p><input type="checkbox"/> Children's Pepto Bismol</p> <p>Other:</p> <p><input type="checkbox"/> Check here for OTC medication not listed Medication Name: _____</p> <p><input type="checkbox"/> Check here for permission for ALL over-the-counter medications listed</p>
<p>*Medications will be administered and dosed according to product directions and the child's weight.</p> <p>Child's Weight (required)</p>	

PARENT'S PERMISSION

I do hereby give permission for the above indicated non-prescription medications to be administered to my child (named above) by the Calvary Day School school nurse or designee. I do hereby release Calvary Day School its administrators, staff and faculty from any and all damages for any accident, injury or illness that may result from or related to the administration of the above indicated non-prescription medications. I hereby authorize the school nurse to share this information with Calvary Day School staff as necessary for the safety and welfare of my child during the school year.

PARENT/GUARDIAN SIGNATURE

DATE

PHYSICIAN'S PERMISSION

I do hereby give permission for the above indicated non-prescription medications to be administered to the student (named above) by the Calvary Day School school nurse or designee.

PHYSICIAN SIGNATURE

DATE