

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 tablets every 4-6 hours

-OR-

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

_____ **Diphenhydramine/Benadryl** 25 mg tablet, 1-2 tablets every 6 hours (not for seasonal allergies)

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

_____ **Calcium Carbonate (Tums)** 500 mg tablet, chew 2-4 tablets, once per day

Stock medications will not be administered for more than three (3) days in a row or eight (8) days per month without documentation from a medical practitioner.

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) _____