

POTH ISD

Phone: (830) 484-2700 Fax: (830) 484-0197

CONSENT FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATIONS for the 2026-2027 School Year
(Must be renewed each year.)

Student's Name: _____ Grade: _____ Date of Birth: _____

Medication Allergies: _____

Medication currently receiving: _____

****The medications listed below can be administered to a student with a parent's signature. Medication must be in the original, unopened container labeled with their student's name. All medications must be hand delivered to campus by an adult, not sent in with student.****

Check all medications that may be given. Medication will be administered based on medication label, unless otherwise prescribed by a healthcare provider.

	Medication	Reason	Dose	Route	Frequency	Special Instructions
☐	Ibuprofen/ Motrin	Pain, Fever, Headache	Per medication label	PO	Per medication label	
☐	Acetaminophen/ Tylenol	Pain, Fever, Headache	Per medication label	PO	Per medication label	
☐	Diphenhydramine/ Benadryl	Allergies, Allergic Reaction, insect bites/ stings	Per medication label	PO or Topical Cream/Gel	Per medication label	
☐	Antacid Tablets/ Tums Pepto-Bismol	Indigestion	Per medication label	PO	Per medication label	
☐	Cough Drops	Sore throat, cough	Per medication label	PO	Per medication label	
☐	Antibiotic Ointment	Abrasions	Per medication label	Topical	Per medication label	
☐	Anti-itch Lotion/Cream (Hydrocortisone, Calamine)	Insect bites/ stings	Per medication label	Topical	Per medication label	
☐	Aquaphor, Eucerin, Aloe Vera	Dry skin	Per medication label	Topical	Per medication label	

Please note School policy does not permit the student to self-carry the over-the-counter medications.

Parent/Guardian Signature: _____ Date: _____ Phone: _____