

St. Michael's Episcopal Day School

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**2026-2027 School Year
OVER-THE-COUNTER (OTC) MEDICATION IN SCHOOL FORM**

Student Name: _____ Birthdate: _____ Grade: _____

Parent/Guardian Name(s): _____

Phone Number(s): _____

Section 1: IMPORTANT INFORMATION *Please read carefully before completing this form.*

This form applies only to over-the-counter medications. Prescription medications and emergency medications require the school's **Prescription & Emergency Medication in School Form** and any applicable emergency care plan.

No over-the-counter (OTC) medications, including items such as cough drops, lozenges, ointments, and topical creams, may be carried in a backpack, lunchbox, pocket, or on a student's person. For student safety, all OTC medications covered by this form must be stored securely and administered by the school nurse or trained designated staff.

A completed authorization form signed by both a parent/guardian and a licensed healthcare provider must be on file before any OTC medication may be administered at school.

Section 2: OPT OUT OPTION

If checked, complete the student and parent information above only, then sign and return this form.

☐ **I decline authorization for ALL OTC medications for my child.**

Parent/Guardian Signature: _____ Date: _____

Section 3: Consent & Acknowledgment for Over-the-Counter Medications

By signing below, I confirm that I have read and understand the following:

- Both a parent/guardian signature and a licensed healthcare provider signature are required each school year for over-the-counter medications to be administered at school.
- My child may not carry OTC medications in a backpack, lunchbox, pocket, or on their person. OTC medications covered by this form must be stored securely and administered by the school nurse or trained designated staff.
- All OTC medications will be administered according to the manufacturer's label directions for the student's age and weight, or as otherwise directed by a licensed healthcare provider.
- In the nurse's absence, a trained designated staff member may administer OTC medications in accordance with school procedures and this completed authorization form.
- I release the School and its employees, agents, and designated staff from liability related to adverse reactions or other outcomes resulting from medication administered in accordance with this completed authorization form, except as otherwise prohibited by law.
- I authorize the school nurse or trained designated staff to administer the medications approved below to my child as needed.

Parent/Guardian Signature: _____ Date: _____

Please check "Yes" or "No" for each medication you permit the school nurse or trained staff to administer. Both parent/guardian and licensed healthcare provider signatures are required for approval.

Ibuprofen (Motrin, Advil)	☐ Yes	☐ No
Acetaminophen (Tylenol)	☐ Yes	☐ No
Diphenhydramine HCL (Benadryl)	☐ Yes	☐ No
Cetirizine HCL (Zyrtec)	☐ Yes	☐ No
Calcium Carbonate 400 (Pepto Kids)	☐ Yes	☐ No
Calcium Carbonate 750 (TUMS for age 12 and older only)	☐ Yes	☐ No
Topical Aquaphor (Petroleum Jelly)	☐ Yes	☐ No
Hydrocortisone Cream 1% for minor skin irritation or rash	☐ Yes	☐ No
Benadryl Itch Cream (1% Diphenhydramine HCL, 0.1% Zinc acetate) for bug bites	☐ Yes	☐ No
Bacitracin Zinc Ointment (500 units/gram) for minor cuts and scrapes	☐ Yes	☐ No
Burn Cream with Lidocaine (0.13% Benzalkonium Chloride antiseptic, 0.5% Lidocaine HCL external analgesic) for minor burns	☐ Yes	☐ No
Sting Relief Pads (6% Benzocaine, 60% Isopropyl Alcohol)	☐ Yes	☐ No
Cough drops for cough or sore throat	☐ Yes	☐ No
**Simethicone (Gas Relief)	☐ Yes	☐ No
**Loperamide (Anti-diarrheal)	☐ Yes	☐ No
**Dextromethorphan HBr, Phenylephrine HCL, Acetaminophen (Dayquil Cold & Flu)	☐ Yes	☐ No
**Dextromethorphan HBr, Doxylamine succinate, Acetaminophen (Nyquil Cold & Flu)	☐ Yes	☐ No
**Dramamine (Meclizine 25-mg)	☐ Yes	☐ No

****Medications marked with ** are only available for administration during overnight school field trips if approved on this form and handled according to school procedures. These medications are not routinely available for administration during the regular school day in the nurse's office.**

Section 3: Licensed Healthcare Provider Authorization for Above OTC Medications To be completed by the licensed healthcare provider.

By signing below, I authorize the OTC medications selected above to be administered by the school nurse or trained designated staff according to the manufacturer's label directions for the student's age and weight, unless otherwise noted below.

Licensed Healthcare Provider Signature: _____ Date: _____

Phone: _____ Address: _____