Cincinnati Public Schools

Authorization for Administration of Over-the-Counter Medications at School

This form expires at the end of the current school year (2026-27)

Student's Name _____ Date of Birth _____ School Year _____

Street Address _____ Apt. No. _____ City _____ State _____ Zip _____

School _____ Grade _____ Homeroom _____

As this student's parent/guardian, I give permission for my child to receive the following over-the-counter medications during school hours or during school sponsored events. In order for CPS staff to administer OTC medications, I agree to provide the medication my child needs in the original labeled container with the protective seal intact.

Physician to complete: Circle yes or no and complete order details for each medication listed below

Name of Medication and Indication	Circle		Dosage	Time/Frequency	Student Can Self-Carry/Administer *Grade 7-12 ONLY*
Acetaminophen (Tylenol) for headache, toothache or minor pain	Yes	No			☐
Ibuprofen for headache, toothache, minor pain or menstrual cramps	Yes	No			☐
Anti-itch cream or lotion	Yes	No			☐
Cough drops	Yes	No			☐
Tums (antacid)	Yes	No			☐

Is the student allergic to any medications? ☐ No ☐ Yes, allergic to _____

Severe reactions that should be reported to the physician: _____

Student's Medical Provider ***Complete dosage and frequency above and sign.***

Provider's Signature:_____ Date: _____

Provider's Name: _____ Emergency Phone: _____

I give permission to Cincinnati Public Schools to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless Cincinnati Public Schools and its agents from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information.

_____ _____

Signature of Parent or Guardian Date

_____

Print Name of Parent or Guardian

How can we reach you during school hours?

Work Phone _____ Cell Phone _____ Home Phone _____ Other _____