

School Year: 20____ - 20____
New forms must be completed
every year.



Permission to Administer Over-the-Counter Medication
Haysville Public Schools
Health Service Department

Student Name: _____ **Date of Birth:** _____ **Grade:** _____

Board Policy:

OVER-THE-COUNTER (OTC) MEDICATION WILL BE GIVEN AT SCHOOL ONLY UPON WRITTEN REQUEST FROM THE LAWFUL GUARDIAN. THIS WRITTEN REQUEST IS REQUIRED BEFORE ADMINISTRATION OF MEDICATION IS INITIATED.

OTC medications must be provided by the guardian in the original container and will be given per label instructions unless otherwise indicated by a physician. Additionally, the student must have taken the OTC medication previously without adverse reaction. OTC medications that will require a physician order include homeopathic/herbal medications and aspirin (or medications containing aspirin). **All OTC medications will be given on an as needed basis and a physician order will be needed if label instructions indicate a daily dose.** These medications must be stored in a locked cabinet in the health room.

OTC Treatment Permission: Please mark (x) by each OTC you approve of for use for your child.

Topical:

____ Antibiotic cream for minor cuts/scrapes
____ Hydrocortisone Cream for itching/eczema/dermatitis
____ Calamine for minor rashes/bug bites/poison ivy
____ Sunscreen
____ Lotion or Vitamin E for dry skin
____ Eye drops for dryness
____ Other: _____

Oral:

____ Acetaminophen* (Tylenol) for minor headaches/aches/pain
____ Ibuprofen* (Advil, Motrin) for minor headaches/aches/pain
____ Antacids (Tums or equivalent) for indigestion
____ Antihistamine for allergy symptoms or allergic reaction
____ Cough drops / Throat lozenges
____ Cough syrup
____ Other: _____

*Acetaminophen and Ibuprofen will not be given together without a physician's order. Please choose and send one or the other.

Child has taken the above medication(s) previously without an adverse reaction: Yes ☐ No ☐

I relieve Haysville USD 261 of any responsibility for the consequences of administering the requested OTC medication and acknowledge that the school incurs no liability for damage, injury, or death resulting directly or indirectly from the administration of the requested OTC medication.

Parent/Guardian Signature

Date

Parent/Guardian Name: _____

Phone: _____

Comments/Special Instructions from parent: _____

