Sault Ste. Marie Public Schools
Authorization form for Over the Counter
Medications approved by physician & parent/legal guardian

Student's name:_____ School:_____
Birth date: ____/____/_____ Name of Physician_____

Please check box of what you approve
Following directions as indicated on box or bottle for age & or weight

Headache,fever or pain
Children's Tylenol or ibuprofen or Midol
☐

Upset stomach
Children's Pepto Bismul/Tums/Rolaids
☐

Allergy
(sneezing, watery eyes, runny nose,itchy throat) Benadryl (diphenhydramine HCL 25 mg)
☐

Cough or sore throat
Cough drops
☐

Diarrhea/loose stools
Anti-diarrheal (loperamide HCl 2 mg)
Not for 6-year-olds or younger or under 47 pounds.
☐

Eye drops
For eye debris or irritation
☐

Rash or itchy skin
Wash, dry, apply skin lotion if dry skin or hydrocortisone cream if itchy, or Vaseline or petroleum jelly to soothe an abrasion once clean.
☐

Mouth & or lips Medication
Canker sore medication
lip balm
☐

Physician / Nurse Practitioner signature: _____

Parent / Legal Guardian signature: _____