Over-the-Counter Medication Authorization

Student Name: _____ **Student DOB**: _____

Ibuprofen (i.e. Motrin, Advil)	☐ Yes ☐ No
Acetaminophen (i.e. Tylenol)	☐ Yes ☐ No
Allegra (fexofenadine)	☐ Yes ☐ No
Diphenhydramine HCl (i.e. Benadryl)	☐ Yes ☐ No
Bismuth Subsalicylate (i.e. Pepto-Bismol) (12y or older) or Calcium Carbonate (i.e. Pepto Kids) (11yr or younger)	☐ Yes ☐ No
Hydrocortisone Cream 1%	☐ Yes ☐ No
Neosporin	☐ Yes ☐ No
Saline eye drops	☐ Yes ☐ No
Sting Relief Wipes (Benzocaine 6% and Isopropyl Alcohol 60%)	☐ Yes ☐ No

This medication order is valid for one year from the date of signing.
I request that the medications noted on this form be given to this student during school hours and at school-sponsored events. I understand that only the school nurse, appointed school personnel, or a designated adult/volunteer chaperone may administer medication unless the "Self-Carry and Self-Administration Authorization" section of this form is complete. In that case, the parent/guardian and student have determined that the student can safely self-administer medication during overnight trips. The school shall incur no liability as a result of any conditions from the medication; I shall hold harmless the school, its employees, or agents against any claims arising from the administration of medication to this student.

Optional - Self-Carry and Self-Administration Authorization (For Overnight Trips) *Middle & Upper School Students Only*:
Please complete if your MS/US student will carry and/or self-administer medication during school-sponsored overnight trips.

Parent/Guardian Acknowledgment:

- ☐ I agree to allow my child to bear the responsibility of carrying the medications listed above
- ☐ I agree to allow my child to bear the responsibility of self-administering the medications listed above
- ☐ My child is able to demonstrate proper use and care of the medications listed above.

Student Acknowledgment:

- ☐ I plan to keep the medications above with me during overnight trips
- ☐ I will use these medications in a responsible manner, as directed by my healthcare provider.
- ☐ I will notify school staff if I have difficulty managing my medication or the condition I use it for.
- ☐ I will not share these medications with others.

Student Signature: _____ **Date**: _____

Physician, CRNP or PA Signature: _____ **Phone:** _____

Printed name of physician, CRNP or PA: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date**:_____

Must be signed by the student's parent/guardian and the student's health care provider (pediatrician, nurse practitioner, or physician assistant).