

School: _____

Phone: _____ Fax: _____

CONSENT FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATIONS for School Year _____
(Must be renewed each year.)

Student's Name: _____ Grade: _____ Date of Birth: _____

Weight: _____ lbs. _____ kg (if needed for dosage) Allergies: _____

Medication currently receiving:

****Parents/guardians must provide medication to School Nurse in the original, unopened container labeled with their student's name and homeroom. All medications must be hand delivered to the School Nurse by an adult, not sent in with student.****

Check all medications that may be given and specify dose and frequency in the chart below. If you prefer that no over-the-counter medications be administered to your child at school, please check the box below.

	Medication	Reason	Dose	Route	Frequency	Side Effects
<input type="checkbox"/>	Ibuprofen/ Motrin					
<input type="checkbox"/>	Acetaminophen/ Tylenol					
<input type="checkbox"/>	Diphenhydramine/Benadryl					
<input type="checkbox"/>	Antacid Tablets/ Tums					
<input type="checkbox"/>	Cough Drops					
<input type="checkbox"/>	Antibiotic Ointment					
<input type="checkbox"/>	Anti-itch Lotion/Cream (Hydrocortisone, Calamine)					
<input type="checkbox"/>	Aquaphor, Eucerin					

Note any special instructions for medications to be given (e.g. take with food): _____

Please note School policy does not permit the student to self-carry the over-the-counter medications.

I do not wish my child to receive any over-the-counter medications at school. (No Doctor's Signature is required.)

Parent/Guardian Signature: _____ Date: _____ Phone: _____

Doctor's Signature: _____ Date: _____ Phone: _____

School Nurse Signature: _____ Date: _____ Phone: _____