



Over The Counter Medications Permission Form

Dear Parent/Guardian:

In the event that your child complains of a minor illness, (e.g. headache, stomachache, cough or cold symptoms, sore throat, or minor aches and pains) during the school day, we can give them symptomatic relief with the **over the counter (OTC) medications** listed below that may be administered to your child by the School Nurse or delegated staff.

Exceptions: If your child requires an over the counter medication on a regular basis, you will need to provide that medication to the school nurse.

Prescription medicines required to be given at school must still follow the appropriate process and not be included here.

Please check this box if you give consent for all of the OTC medications listed below on this form

If you do not give consent for all of these OTC medications, please check all the medications that you consent to your child receiving if they come to the School Nurse requesting symptom relief.

- | | |
|---|---|
| <input type="checkbox"/> Advil/Ibuprofen (headaches, aches & pains) | <input type="checkbox"/> Eye Wash (foreign object) |
| <input type="checkbox"/> Calamine Lotion (poison ivy, oak, or sumac) | <input type="checkbox"/> Natural Tears (dry eye) |
| <input type="checkbox"/> Acetaminophen/Tylenol (headaches, aches & pains) | <input type="checkbox"/> Saline Solution (contacts) |
| <input type="checkbox"/> Antacid/Tums (stomach aches) | <input type="checkbox"/> Sting Kill Swabs (insect sting) |
| <input type="checkbox"/> Anbesol / Orajel (tooth aches) | <input type="checkbox"/> A&D Ointment/petroleum jelly (skin irritation) |
| <input type="checkbox"/> Cough Drops/Hall's (sore throat, cough) | <input type="checkbox"/> Bactine (clean superficial wounds) |
| <input type="checkbox"/> Eye Drops/ Zaditor/Ketotifen (allergies) | <input type="checkbox"/> Chapstick (dry lips) |
| <input type="checkbox"/> Hydrocortisone Cream | <input type="checkbox"/> Hydrogen Peroxide (cleanse wounds) |
| <input type="checkbox"/> Loratadine or Cetirizine (allergies) | <input type="checkbox"/> Cepacol/Hall's/generic Lozenges (sore throat) |
| <input type="checkbox"/> Diphenhydramine or Benadryl (allergies) | |
| <input type="checkbox"/> Triple Antibiotic/Neosporin, Bacitracin (minor wounds) | |

Child's name: _____ Grade: _____

Allergies: _____

Parent/Guardian Signature: _____ *Date: _____

***This consent is valid only for the current school year (summer dates extend to next school year). A new consent must be completed at the start of each school year.**