



Authorization for Nonprescription Medication or Treatment

To the Parent:

The following information is necessary for any student to use nonprescription medications in school. All spaces must be completed.

Student Name	Date of Birth	Weight	School
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Grade	Medication Allergies
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Medications Taken at Home

A: PLEASE INITIAL EACH MEDICATION FOR WHICH YOU ARE GIVING PERMISSION

_____ I approve all medications listed below.

_____ I do not want any OTC medications given to my student.

Topical:

- ___ Antibiotic cream (i.e. Bacitracin, Neosporin)
- ___ Caladryl lotion
- ___ Hydrocortisone cream 1%
- ___ Benadryl Cream 2%
- ___ Sunscreen
- ___ Oragel(20% benzocaine)
- ___ First Aid ointment (5% benzocaine/antiseptic)
- ___ Eye drops for dryness (Refresh)

Oral:

- ___ Ibuprofen (Advil, Motrin)
- ___ Acetaminophen (Tylenol)
- ___ Antacid (Mylanta, Maalox, Tums)
- ___ Cold Medication (Guafenesin, Tylenol, dextromethorphan, phenylephrine)*
- ___ Antihistamine (Benadryl, Loratadine*, Cetirizine*)
- ___ Cramp Tab (tylenol, pamabrom)*
- ___ Migraine Formula (Tylenol, Aspirin, Caffeine) for migraines*
- ___ Dairy Relief(Lactaid)*
- ___ Loperamide (Immodium)*
- ___ Famotidine 20mg.(Pepcid)*
- ___ Motion Sickness (meclizine)*
- ___ Cough Drops (menthol)*

**Available only at the secondary level*

The Medications Indicated Above May Be Administered to My Student

Signature of Parent/Guardian	Date
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OTC medications will be given at the recommended package dosage and directions by the School Nurse/Registered Nurse/Designated Staff. The school is not able to supply medication for frequent or daily use.

For OTC medications not listed on this form, or if the medication must be given frequently, please use the area below.

B. I am requesting permission for my child named above to use or receive the following over-the-counter medication(s):

Medication	Dosage
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Initial option below:

- Have medication(s) administered by a Designated District Employee.
- Self Administer such medication(s) in the presence of a Designated District Employee.
- Keep the medication(s) in his/her possession and self administer the medication(s) as needed.

- C. I will assume responsibility for safe delivery of the medication to school in its original container.
- D. I will notify the school immediately if there is any change in the use of the medication or treatment.
- E. Our physician has instructed that this medication should be administered in the above-designated dosage.
- F. I release and agree to hold the Board, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.
- G. I will call the school nurse and send a written note if my student is taken off this medication. I will retrieve the medication within three (3) days. I understand the medication will be disposed of after three days.

Parent/Guardian Signature	Date	Phone Number
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