USD 410 School District **School Year: _____**

New forms must be completed every year

PARENT PERMISSION TO GIVE "OCCASIONAL" OVER-THE-COUNTER MEDICATION

Student Name_____ School _____ Grade_____

Over-the counter (OTC) medications are drugs that do not require a prescription and are purchased "over-the-counter." This form is required before over-the-counter medications can be administered at school.

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. Triple Antibiotic Ointment, Bacitracin Cream, Polysporin)
_____Hydrocortisone cream (i.e. Cortaid)
_____Benadryl cream (i.e. Caladryl, Diphenhydramine)
_____Sunscreen
_____Oral products containing benzocaine (oragel, chloraseptic)
_____Tincture of Benzoin, Mastisol (helps tape adhere)
_____Burn gels
_____Eye drops for dryness
_____Diaper Rash Ointment (i.e. Desitin, A&D)

ORAL:

_____Ibuprofen (i.e. Advil, Motrin, Nuprin)
_____Acetaminophen (i.e. Tylenol)
_____Antacid (i.e. Mylanta, Maalox, Tums)
_____Cold Medications (Guaifenesin, Pseudoephedrine, Phenylephrine)
_____Antihistamine (i.e. Benadryl Loratadine)
_____Cough syrup (Dextromethorphan, plain or medicated cough drops)

Please check with the school nurse to see which medications are available for occasional use at the school and which medications you will need to supply. OTC medications will be given at the manufacturer's recommended dosage. The school is not able to supply medication for frequent or daily use.

THE MEDICATIONS INDICATED ABOVE MAY BE ADMINISTERED TO MY STUDENT

_____ _____
(Signature of Parent or Guardian) **Date**

When sending OTC medications to school, they must be in the original manufacturer's container with the label intact or the medication will not be accepted. For safety reasons, parents are requested to bring the medication directly to the nurse. In the event that an adult is unable to bring the medicine to school, arrangements may be made by calling the nurse.

MEDICATION HISTORY:

Is your student allergic to any medications? _____ If yes, please list medicine(s) and type of reaction:

_____

_____

Does your student take any medication (either over-the-counter or prescription) on a regular basis? _____

If yes, please list: _____