SCHOOL YEAR_________

PARENT CONSENT FOR APPROVED OVER-THE-COUNTER MEDICATIONS

**THIS FORM MUST BE COMPLETED BEFORE ANY MEDICATION WILL BE GIVEN AT SCHOOL

Student Name:______________________________Grade_______DOB_________

I give my permission for my child_______________________to receive the medication I have checked below. I understand that these medications will be given at the discretion of the school nurse only.

Does your child have any allergies to medications?_____________________________

Is your child taking any daily medications?__________________________________

_____**Tylenol**
May be given for fever, headache, dental pain, menstrual cramps, injury

_____**Anbesol**
May be given for toothache, gum pain, canker sores

_____**Cough drops**
May be given for cough or sore throat

_____**Benadryl** (you will be called first)
May be given for a severe allergic reactions- rash, hives, swelling, or redness

_____**Ibuprofen**
May be given for fever, headache, dental pain, menstrual cramps, injury

_____**Natural Tears**
May be given for eye irritation

_____**Benadryl Cream/hydrocortisone 0.5%**
May be given for insect bites, poison ivy, red and itchy skin

_____**Triple Antibiotic Ointment**
Applied to cuts, scrapes along with a band-aid

_____**Tums/Maalox**
May be given for epigastric pain and upset stomach

I also understand that medications may be given only once during any school day. If medications are requested more than two times in any week or if a regular pattern of use develops, parents will be notified and advised to seek Physician consultation.

Parent/Guardian Signature__________________________________Date________
Parent E-mail address (used for non-emergency notifications) ____________________________
Phone # (H)________________(W)____________________(C)_______________
Emergency Contacts: Name________________________ Phone #______________
Name________________________ Phone #______________