

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

ALL Grades

Student Name _____ School _____ Grade _____

Parent Name _____ Phone Number to contact _____

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. Exceptions to this are homeopathic/herbal medications and aspirin, which require completing the form "Medication Administration Request"

Responsible middle school and high school students are encouraged to manage their own OTC medication needs in order to minimize time out of class. Parents should prepare their student for this responsibility. The medication should be transported in the original container with an intact label. The student should use the medication in accordance with the instructions, and medication should not be shared with classmates. Students who misuse this privilege may be subject to disciplinary action per applicable school board policies. Please contact your school nurse for additional information.

Elementary Students are *NOT allowed* to self-carry medications while at school, for maturity and safety reasons. This includes Chap Stick, lotion, creams, cough drops and ointments.

PLEASE INITIAL EACH MEDICATION FOR WHICH YOU ARE GIVING PERMISSION

I, _____, approve all medications listed below

TOPICAL:

- _____ Antibiotic cream (i.e. Bacitracin Cream, Polysporin)
- _____ Hydrocortisone cream (i.e. Cortaid)
- _____ Anti-Itch Creams products (Calamine, Caladryl)
- _____ Sunscreen
- _____ Aloe Vera Gel
- _____ Eye drops (Saline solution)
- _____ Lip products (Carmex or Vaseline)

ORAL:

- _____ Ibuprofen (i.e. Advil, Motrin, Nuprin)
- _____ Acetaminophen (i.e. Tylenol)
- _____ Antacid (i.e. Mylanta, Maalox, Tums)
- _____ Peppermints

Please check with the school nurse to see which medications are available for students in the school clinic for occasional use, and which medications you will need to supply if you want the clinic to administer them. Generic equivalents may be used. OTC medications will be given at the manufacturer's recommended dosage.

THE MEDICATIONS INDICATED ABOVE MAY BE ADMINISTERED TO MY STUDENT	
_____	_____
(Signature of Parent or Guardian)	(Date)

The School Nurse or delegated staff person will administer as deemed necessary using his/her judgement. I understand and agree that USD 342 and any school employee who administers these medications according to proper dosage shall not be held liable for damages as a result of an adverse reaction to the medication administered. 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 daily, please use the form "Medication Administration Request." **Initial here** _____

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: _____