Medication Permission Form

Student Name: ____________________________ Date of Birth: ____________

In order for over-the-counter (OTC) medications to be given to your child we must have your written permission. This form is in lieu of a telephone call each time your child requires medication. It is understood that parents will be notified if the requests for such medication are excessive.

Dosing and formulation of medication will be determined by the school nurse and will be age and weight appropriate.

PLEASE INITIAL EACH MEDICATION FOR WHICH YOU ARE GIVING PERMISSION

________ I DO NOT WANT *ANY* OTC MEDICATIONS GIVEN TO MY CHILD

Topical:

______ Antibiotic cream (Bacitracin/Neosporin Triple Antibiotic ointment)

______ Hydrocortisone cream

______ Anti-itch cream (Benadryl cream, Caladryl lotion)

______ Sunscreen

______ Aquaphor/Vaseline/Lotion

______ Eye drops for dry/itchy eyes

______ Burn gel/cream

Oral:

______ Acetaminophen (Tylenol)

______ Ibuprofen (Motrin/Advil)

______ Antacid (Tums)

______ Antihistamine (Benadryl)

______ Cough drop/throat lozenge

THE MEDICATIONS INDICATED ABOVE MAY BE ADMINISTERED TO MY CHILD

______________________________________ __________

(Signature of Parent/Guardian) **(Date)**

Allergies: ____

Notes: ____

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