Medication Permission Form

Student Name: _____ Date of Birth: _____

2020/2021 Grade: _____

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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