



OVER-THE-COUNTER MEDICATION CONSENT

Student Name _____ Date of Birth _____

Medication Allergies/Sensitivities _____

List any long-term medication your child receives: _____

Medical/health problems: _____

I give permission for my child _____ to receive any medication listed below on this form as deemed necessary by authorized School personnel. I understand that generic equivalent medications may be used. All medication to be administered will be given orally (liquid, chewables or tablets). Dosages will be age and weight appropriate and will be given on a prn (as needed) basis as per the directions on the label.

I would like the following medication(s) made available to my child (please circle – if medication is not circled, it will be withheld):

For headache/fever/earache/muscle aches/pain/menstrual cramps:

Acetaminophen (Tylenol), 500mg orally every 4-6 hours as needed or specify dose:

Ibuprofen (Advil), 200mg orally every 4-6 hours as needed or specify dose:

For sore throat:

Throat lozenges

For mild allergic reactions:

Diphenhydramine (Benadryl), 25mg orally or specify dose:

For coughs

Cough drops

For upset stomach

Chewable antacid tablets (Tums), one or two tablets as needed

I understand that authorized School personnel under the direction of my child's physician will administer the above medications I have checked. (Medications will NOT be administered without physician's signature below.)

Signature of Parent/Guardian

date

Signature of Physician

date