

Administration of OTC (Over The Counter), Non-Prescriptive Medicine at School

When possible, medications should be given to students before or after school by the parent or guardian. Over the counter medications may only be given within the limits and according to the instructions printed on the container or the package insert. Medications must be provided to the school by the parent or guardian in the original container.

Child's Name _____ Date of Birth _____

Is your child allergic to any food, medicines, or other items? No Yes
(If yes, list allergies.) _____

I give my permission for the school to administer the following OTC medicines to my child during the school day, as per the label's instructions, without further contact with me (check as many or few as desired):

- | | |
|--|--|
| <input type="checkbox"/> Ibuprofen (Advil, etc) | <input type="checkbox"/> Antacid (Tums, etc) |
| <input type="checkbox"/> Acetaminophen (Tylenol, etc) | <input type="checkbox"/> Indigestion (Pepto-Bismol, etc) |
| <input type="checkbox"/> Antihistamine (Benadryl, etc) | <input type="checkbox"/> Zyrtec |
| | <input type="checkbox"/> Claritin |

Name of any *additional* or *other* OTC medications to be given at school:

Reason for medication and instructions to administer (including dosage and timing):

Note any special storage requirements: Refrigerate Other (please specify)

Does your child take any other medications at home or at school? No Yes
(If yes, what are the medications?) _____

Child's Health Care Provider's Name and Address (please print):

Office Phone Number:

I give permission for the medication noted above to be given to my child during the school day. I give permission for the school administrator to contact the health care provider named above to discuss this medication and my child's health. I give permission for the health care provider named above or his/her designated employees to provide information about this medication and my child's health to the school administrator. I understand that I am responsible for notifying the school if any of my child's medications change.

Signature of Parent / Guardian

Date

Print or Type Name of Parent / Guardian

Day Phone Number

