Student Name: _____ Date of Birth: _____ Grade: _____

AOS92

PERMISSION FOR ADMINISTRATION OF NON PRESCRIPTION MEDICATION

I give permission for the school nurse to give the following non-prescription (over-the-counter) medication to my daughter/son, as needed, to manage minor health issues such as sore throat, headache and upset stomach. I understand that the generic equivalent medication may be used. The dose of medication will be based on age and/or weight as directed on the medication label. If your doctor has requested a dose above or below the amount listed on the label, a doctor's note must be provided.

Medication Allergies/Sensitivities: _____

Daily Medication your child receives at home: _____

*** Please **circle Yes or NO** for each item your daughter/son has permission to receive during the school day. (All items can be selected). If you **Do Not** want your daughter/son to receive medications, please check item at the bottom of this form. Form must be signed, dated and returned to school personnel.

Pain Relievers (for minor pain and fever)

Yes No Acetaminophen (Tylenol)

Yes No Ibuprofen (Advil, Motrin)

Antihistamines (for allergies)

Yes No Diphenhydramine (Benadryl)

Cough and cold relievers (sore throat or cough)

Yes No Cough Drops

Yes No Throat Lozenges

Antacids (for upset stomachs)

Yes No Tums

Topical Ointments (for skin rashes and itching, burns)

Yes No Bacitracin ointment Yes No Hydrocortisone cream Yes No Caladryl lotion

Yes No Burn cream/spray Yes No Orajel/Orasol gel (for dental discomfort)

I understand that the above medications will be administered in accordance with state and school protocols.

Parent/Guardian Signature: _____ Date: _____

____ I **DO NOT** want my child to receive any medications while at school

Parent/Guardian Signature: _____ Date: _____