OVER - THE - COUNTER MEDICATION AUTHORIZATION FORM

Olin Elementary School

Student Name:_____D.O.B:_____Grade_____

Select Over-the-Counter (OTC) medication may be administered, if we have written permission from the student's parent/guardian. Unless we have parental/guardian permission, we will not administer any medications or make OTC medications available to students unless necessary as part of general first-aid treatment.

I give permission to the school nurse or trained school personnel to administer the following medications to my child consistent with medication directions, if the need arises.

Check all that apply:

___Diphenhydramine (Benadryl): swelling, hives, allergic reaction

___Calamine Lotion: insect bites and mild skin irritations

___Hydrocortizone cream: insect bites and mild skin irritations

___Ibuprofen (Motrin/Advil): headache, minor aches, toothaches, menstrual cramps

___Antacids (Tums): acid reflux, heartburn, or indigestion

___Throat Lozenges or Cough Drops: sore throat or cough

___Acetaminophen (Tylenol): headache, minor aches, toothaches, menstrual cramps

___Visine or other eye drops: minor eye irritation

___Ointments for minor wound care, such as an antiseptic, anti-itch, anti-sting, triple antibiotic, Orajel (toothaches or canker sores), or burn cream

Any condition which is associated with fever, significant inflammation, and/or does not respond to the above outlined OTC treatment will be followed-up with the parent/guardian. Parent/guardian will be contacted if any conditions develop requiring treatment with any of the above over-the-counter medications that are not checked. I authorize the administration of checked OTC medications to my child as indicated above and general first aid treatment.

Parent/Guardian Signature:_____Date:_____