Permission for Use of Over -The- Counter Medications during the Current School Year!

Name of Student: Date:

Does your child have allergies to medicine, food, latex or insect bites: Yes No

If yes: To What? What Happens? \_

Treatment:

As parent/guardian, I give my permission for the above-named student to have the following medications administered by the school nurse during the current school year. I understand that he/she will be checked by the school nurse and the medications will be administered if indicated following the nurse's assessment. Please check only those medications you wish to be given to your child when needed

\_\_\_\_\_\_Medicated Powder/Baby Powder \_\_\_\_\_\_Mineral lce (muscle pain)

\_\_\_\_\_\_Sting Kill (Insect Sting relief) \_\_\_\_\_\_Throat Spray(Chloreseptic Spray)

\_\_\_\_\_\_Anbesol/Oragel ( mouth Pain) \_\_\_\_\_\_Anti fungal Cream

\_\_\_\_\_\_Benadryl Lotion ( anti- itch) \_\_\_\_\_\_Blistex (lip ointment)

\_\_\_\_\_\_Burn Ointment/ Spray \_\_\_\_\_\_Vicks (vapor rub)

\_\_\_\_\_\_Triple Antibiotic Ointment \_\_\_\_\_\_Caladryl Lotion

\_\_\_\_\_\_Calamine Lotion (anti-itch) \_\_\_\_\_\_Advil/ lbuprofen

\_\_\_\_\_\_Tylenol/Acetaminophen \_\_\_\_\_\_Carmex (mouth lesions)

\_\_\_\_\_\_Chapstick(lip balm/Vaseline) \_\_\_\_\_\_Tums (antacid)

\_\_\_\_\_\_Benadryl \_\_\_\_\_\_Contact lens solution/saline/ rewetting

\_\_\_\_\_\_Cough drops \_\_\_\_\_\_Eye Wash solution

\_\_\_\_\_\_Hydrocortisone cream \_\_\_\_\_\_ Zyrtec

If your child requires prescription medication during the school day, please contact your child's school nurse

ex. Medication for: ADHD, ADD, Diabetes, Seizures, Asthma medications (inhalers, nebulizer medication), Ep- pens etc.

Students may not carry medications during the school day without Parent/Doctor/School Nurse permission. Paperwork must be completed and on file in the nurse’s office.

PARENT/GUARDIAN SIGNATURE Date: