

# CCS Non-Prescription Medication Authorization-08/08-06/09

Students often have minor ailments and complaints that prohibit maximum effort in school, but can be eased with simple over-the-counter remedies. The nurse or trained staff may also use alternate methods of care (ICE PACKS, REST) when possible.

We require written permission annually from you and your physician for each child, if our nurse or trained staff is to give intermittent non-prescription remedies. Students who routinely use certain meds are encouraged to provide their own non-prescription medicine. This medicine will be kept in the nurse's office.

I hereby grant permission for the school nurse or trained staff to dispense only those over-the-counter medications, which are checked below. I release the nurse and school personnel from any liability for the administration of said preparations.

Student's Name	Student's Address		
Signature of Parent of Guardian	Date Signed	Grade	Date of Birth

**Physician, please complete the medicines you permit:**

	<u>Dosage</u>	<u>Frequency</u>	<u>Indications</u>	<u>Reactions</u>
<b>PAIN RELIEF</b>				
<input type="checkbox"/> Ibuprofen	_____	_____	_____	_____
<input type="checkbox"/> Acetaminophen (generic Tylenol)	_____	_____	_____	_____
<input type="checkbox"/> Midol	_____	_____	_____	_____
<b>OTHER</b>				
<input type="checkbox"/> Sudafed	_____	_____	_____	_____
<input type="checkbox"/> Benadryl	_____	_____	_____	_____
<input type="checkbox"/> Hall or Robitussin cough drops	_____	_____	_____	_____
<input type="checkbox"/> Robitussin cough syrup	_____	_____	_____	_____
<input type="checkbox"/> Antacids (Rolaids, Mylanta, Tums)	_____	_____	_____	_____
<input type="checkbox"/> Ammonia inhalants	_____	_____	_____	_____
<b>TOPICALS</b>				
<input type="checkbox"/> Vaseline	_____	_____	_____	_____
<input type="checkbox"/> Triple Antibiotic Ointment	_____	_____	_____	_____
<input type="checkbox"/> Caladryl or Benadryl	_____	_____	_____	_____
<input type="checkbox"/> Hydrocortisone Cream, 0.5 or 1%	_____	_____	_____	_____
<input type="checkbox"/> Visine eye drops	_____	_____	_____	_____
<input type="checkbox"/> Insect sting swabs	_____	_____	_____	_____
<input type="checkbox"/> Solarcaine	_____	_____	_____	_____
<input type="checkbox"/> Aloe Vera Gel	_____	_____	_____	_____
<input type="checkbox"/> Oragel	_____	_____	_____	_____
<input type="checkbox"/> Sports creams	_____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____	_____

(List any additional non-prescription med)

PLEASE LIST ANY DRUG ALLERGIES: \_\_\_\_\_

Please list all routine prescribed medications: \_\_\_\_\_

Physicians Signature	Date signed	Phone Number
----------------------	-------------	--------------