

Non-Prescription Medication Authorization-08/2011-06/2012

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>
PAIN RELIEF				
Ibuprofen	_____	_____	_____	_____
Acetaminophen (generic Tylenol)	_____	_____	_____	_____
Midol	_____	_____	_____	_____
OTHER				
Sudafed	_____	_____	_____	_____
Benadryl	_____	_____	_____	_____
Dimetapp Cold/Allergy	_____	_____	_____	_____
Hall or Robitussin cough drops	_____	_____	_____	_____
Robitussin cough syrup	_____	_____	_____	_____
Antacids (Rolaids, Mylanta, Tums)	_____	_____	_____	_____
Ammonia inhalants	_____	_____	_____	_____
TOPICALS				
Vaseline	_____	_____	_____	_____
Triple antibiotic ointment	_____	_____	_____	_____
Caladryl or Benadryl	_____	_____	_____	_____
Hydrocortisone cream, 0.5 or 1%	_____	_____	_____	_____
Visine eye drops	_____	_____	_____	_____
Insect sting swabs	_____	_____	_____	_____
Solarcaine	_____	_____	_____	_____
Aloe vera gel	_____	_____	_____	_____
Orajel	_____	_____	_____	_____
Sports creams	_____	_____	_____	_____

(List any additional non-prescription med)

PLEASE LIST ANY DRUG ALLERGIES: _____

Please list all routine prescribed medications: _____

Physicians Signature	Date signed	Phone Number
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