## 2021-2022 NON-PRESCRIPTION MEDICATION AUTHORIZATION

(Please note: This is a two-sided document.)

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 alternative 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/Guardian Date Signed Grade Date of Birth

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

| | Dosage | Frequency | Indications | Reactions |
|---|---|---|---|---|
| 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 | | | | |
| Benadryl Ointment | | | | |
| Hydrocortisone cream, 0.5 or 1% | | | | |
| Visine eye drops | | | | |
| Insect sting swabs | | | | |
| Solarcaine | | | | |
| Aloe Vera gel | | | | |
| Sports creams | | | | |
| ____________ (List any additional non-prescription med) | | | | |

PLEASE LIST ANY DRUG ALLERGIES:_______________________________________

**Please list all routine prescribed medications**: _______________________________________

_______________________ ___________ ___________

Physician's Signature Date Signed Phone Number

# STUDENT PRN MEDICATION LIST

**Student Name** ______________________________________ **Grade** _______ **Year** _______

**Administered By** ____________________________ __________________________________

| Date | Time | Medication | Dosage | Date | Time | Medication | Dosage |
|---|---|---|---|---|---|---|---|
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