

OVER-THE-COUNTER MEDICATION PROTOCOL FOR SCHOOL

The school physician has written a doctor's order for the administration of the medications listed below. If you would like your child to have permission to receive these medications when necessary, please sign where indicated. **Permission must be renewed in writing every year. Consent may be withdrawn at any time by contacting the nurse's office. This protocol covers only the medications listed below.**

PLEASE—ONLY ONE STUDENT PER FORM

Student's Name _____

Grade _____

I give the school nurse permission to administer the following:

____ Tylenol (Acetaminophen)

____ Hydrocortisone ointment

____ Advil (Ibuprofen)

____ Halls cough drops

____ Bacitracin ointment

____ Calamine lotion/Caladryl

____ Benadryl

____ Antacid (Upset stomach)

____ Anbesol gel

____ Visine eye drops

____ Ben Gay

____ **All of the above**

____ **None of the above**

Please list all medications your child is currently taking:

Please list all known allergies your child has:

Any illness, injury, or surgery since last year? _____

Student's Physician _____ Phone # _____

Parent/Guardian's Signature

Date

**NO MEDICATION WILL BE GIVEN WITHOUT WRITTEN
CONSENT ON FILE**