OVER-THE-COUNTER MEDICATION PERMISSION FORM

Grades 7-12

The following over-the-counter medications will be available to students in grades 7-12. Signature on the bottom of this form is my yearly authorization to give my child these medications.

Please check the medication(s) your son/daughter may receive for minor health problems such as a cold, menstrual cramps, headache, sore throat, sore muscles, backache, sprains and upset stomach. These medication(s) will be given following the District's written protocol and with parent/guardian consent. If you have any questions please call the school nurse.

School year: 20 - 20

School building: _____

Student's name: _____ Grade: _____

I give permission for _____ to receive the
(student name)

medication(s) checked below, according to the protocols of the school nurse.

Generic forms of the medications may be used.

☐ ALL MEDICATIONS LISTED

☐ Acetaminophen (e.g. Tylenol)
☐ Ibuprofen (e.g. Advil, Motrin)
☐ Lozenges (Cough drops)
☐ Hydrocortisone cream (Itch-relief)
☐ Nasal decongestants

☐ Acetaminophen/Sudafed (e.g.Tylenol/Sinus)
☐ MS-Aid (e.g. menstrual cramp relief)
☐ Cough syrup
☐ Antihistamine (e.g. Benadryl)
☐ Rolaids, Tums

Please list all known allergies (medication or other): _____

_____

_____

_____ _____
Parent/Guardian signature Date

Approved: April 14, 2008

Reviewed: March 14, 2016

Revised: May 9, 2011