

## 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)

Acetaminophen/Sudafed (e.g. Tylenol/Sinus)

Ibuprofen (e.g. Advil, Motrin)

MS-Aid (e.g. menstrual cramp relief)

Lozenges (Cough drops)

Cough syrup

Hydrocortisone cream (Itch-relief)

Antihistamine (e.g. Benadryl)

Nasal decongestants

Roloids, Tums

Please list all known allergies (medication or other): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date

Approved: April 14, 2008

Reviewed:

Revised: May 9, 2011