The Primary Day School

2014-2015 School Year
Over-The-Counter Medication Parental Consent Form

**Student Name:** _____ **DOB**_____ **Age** _____ **WT** _____
Last First

This form must be completed by a parent for the authorized administration of selected over-the-counter medications.

**ALL MEDICATION WILL BE GIVEN ACCORDING TO AGE/WEIGHT DIRECTIONS ON LABEL.**

Listed below are the over-the-counter medications that are available in the health room. All **other** medications must have your physcian's authorization, your consent and be supplied by the parent.

**Please INITIAL the medications you authorize to be given to your child.**

_____ **Ibuprofen** (i.e., Motrin, Advil) – headache, earache, temperature above 100 F degrees, sore throat pain or minor discomfort

_____ **Acetaminophen** (i.e., Tylenol) – headache, earache, temperature above 100 F degrees, sore throat pain, or minor discomfort

_____ **Diphenhydramine** (i.e., Benadryl) – mild allergic reactions, anaphylaxis (if ordered by student's physician), insect stings

_____ **Cough Drops –** minor sore throat pain

_____ **Hydrocortisone Cream -** minor skin irritations such as insect bites and poison ivy

_____ **Bacitracin Antibiotic Ointment –** cuts and abrasions

_____ **Vaseline Ointment –** chapped lips

_____ **Aloe Vera Gel –** minor rashes, skin irritations

_____ **Dry Skin Lotion -** chapped skin

Parent authorization is required before any over-the-counter medication is administered to a child. Only the School Nurse or delegate will be able to administer medication to your child. This consent is valid for the present school year only. This is an optional service and is intended for occasional use only. **It is against school policy for students to carry any medications with them.**

If your child requires any non-prescription medication on a **regular** basis or a prescription medication, you must obtain a written order from your health care provider on an *Authorization to Administer Medication* form and supply the medication to school.

I give my permission to designated Primary Day School personnel to administer the medications indicated above according to age/weight directions on the medication label to my child. I certify that I have legal authority to consent to medical treatment, including medication administration for the student named above. I authorize the School Nurse to communicate with the health care provider as allowed by HIPPA.

**Parent Signature**: _____ Initials: _____ Date: _____

Phone Numbers: (C)_____ (H) _____ (W) _____

September 2014