The Primary Day School

**School Year 2026- 2027**
**Over-The-Counter Medication Parental Consent Form**

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

_____ **YES** **I give permission for my child to be administered the over-the-counter medications that I sign for below.**

_____ **NO** **I do not give permission for my child to be administered the below over-the-counter medications.**

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 2026 - 2027 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 prescription or non-prescription medication on a **regular** basis, you must obtain a written order from your health care provider on an *Authorization to Administer Medication* form and supply the medication to school. The medication must be in the original container which is readable and current.
By signing your name below each medication, you give permission to designated Primary Day School personnel to administer the medication to your child according to the instructions on the medication container. You certify that you have legal authority to consent to medical treatment, including medication administration for your child named above. You authorize the School Nurse to communicate with your health care provider as allowed by HIPPA.

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

**ALL MEDICATION WILL BE ADMINISTERED ACCORDING TO THE INSTRUCTIONS ON THE MEDICATION CONTAINER**

Listed below are the over-the-counter medications that are maintained in the Health Room. All other medications must have a written physician's authorization, parental consent, and be supplied by the parent.

**Please sign your name below each medication you authorize to be administered to your child.**

**Children's Ibuprofen (Advil/Motrin)** – headache, earache, temperature above 100 F degrees, sore throat or minor physical discomfort
Parent Signature: _____ **Date**: _____

**Children's Acetaminophen (Tylenol)** – headache, earache, temperature above 100 F degrees, sore throat or minor physical discomfort
Parent Signature: _____ **Date**: _____

**Luden's Throat Lozenges** – (**K – 2nd grades only**) minor sore throat discomfort or cough
Parent Signature: _____ **Date**: _____

**Vaseline/Aquaphor Ointment –** chapped lips and skin
Parent Signature: _____ **Date**: _____

**1% Hydrocortisone cream –** insect bites/stings/itching
Parent Signature: _____ **Date**: _____

**Eucerin Dry Skin Therapy –** dry and chapped skin
Parent Signature: _____ **Date**: _____

Revised February 2026