Permission for Over-The-Counter Medications (OTC)

(This permission slip applies only to grades 7 through 12)

Please fill out below:

Student Name:____ **DOB:**_______________

Grade:___________ **School:** ____

Does your child receive any prescribed medication? ☐ Yes ☐ No

If so, name of medication: ____

Dose and Frequency: ____

Does your child have any of the following?

Hearing problems: ☐ Yes ☐ No

Vision problems: ☐ Yes ☐ No

Depression: ☐ Yes ☐ No

Seizure disorder: ☐ Yes ☐ No

ADD/ADHD: ☐ Yes ☐ No

Asthma: ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No

Other medical conditions, If yes, please describe:

____

____

The following medications may be dispensed by the school nurse as needed only once during the school day. The school nurse will not be able to dispense these medication without your signature.

Please check below:

Acetaminophen (i.e. Tylenol): ☐ Yes ☐ No

Diphenhydramine (i.e. Benadryl): ☐ Yes ☐ No

Ibuprofen (i.e. Advil, Motrin): ☐ Yes ☐ No

Antibiotic Ointment: ☐ Yes ☐ No

Antacid (i.e. Tums, Rolaids): ☐ Yes ☐ No

Cough Drops: ☐ Yes ☐ No

Parent/Guardian Signature:_________________________ **Date:**_________________