School Year: 20____ - 20____

New forms must be completed every year.

Permission to Administer Over The Counter Medication

Student Name: _____Date of Birth: _____Grade: _____

Weight: _____

OVER THE COUNTER (OTC) MEDICATION WILL BE GIVEN AT SCHOOL ONLY UPON WRITTEN REQUEST FROM THE LAWFUL PARENT/GUARDIAN. THIS WRITTEN REQUEST IS REQUIRED BEFORE ADMINISTRATION OF MEDICATION IS INITIATED.

OTC medication must be provided by the parent/guardian in the original container and will be given per parent dosage instructions, unless otherwise indicated by a physician. Additionally, the student must have taken the OTC medication previously with no adverse reaction. OTC medications that will require a physician order include homeopathic/herbal medications. Medications containing aspirin will not be administered at school. All OTC medication will be given on an as needed basis and a physician order will be needed if the OTC medication is needed daily or scheduled. These medications must be stored in a locked cabinet in the school office or health room.

***Acetaminophen and Ibuprofen will not be given together without a physician order. Please choose and send one or the other.**

OTC Treatment Permission: Please mark (X) by each OTC you approve of for use for your child.

Topical Medication: Purpose for Use:	Oral Medication: Purpose for Use:
☐ Hydrocortisone Cream -	☐ Acetaminophen (Tylenol) -
☐ Calamine Lotion -	☐ Ibuprofen (Advil, Motrin) -
☐ Lotion -	☐ Antacids (Tums or equivalent) -
☐ Cooling Burn Gel -	☐ Cough Drops or Lozenges -
☐ Other -	☐ Cough Syrup -
☐ Other -	☐ Eye Drops -
☐ Other -	☐ Antihistamine -
	☐ Other -
	☐ Other -

Dose Instructions

_____

Special Instructions

_____

Child has taken the above medication(s) previously without an adverse reaction: YES NO

I relieve St. Joseph, Ost Catholic Church and School of any responsibility for the consequences of administering the requested OTC medication and acknowledge that the school incurs no liability for damage, injury, or death resulting directly or indirectly from the administration of the requested OTC medication.

Parent/Guardian Name _____ Phone Number _____

Parent/Guardian Signature _____ Date _____