



# GLENFOREST SCHOOL

*A Positive Place to Learn*

## PARENTAL PERMISSION FOR OVER THE COUNTER (OTC) MEDICATION TO BE ADMINISTERED BY THE NURSE

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
School Year: \_\_\_\_\_ Grade: \_\_\_\_\_

When possible, all medications should be given to students before school or after school hours by the parent or guardian. The health room now has a limited supply of over-the-counter "stock" medications that may be administered with written permission. Students requesting medication will be evaluated by the school nurse and may receive these medications as comfort measures during school hours. The school nurse may contact you to discuss the frequency of your child's request for medication, or recommend follow up care with your health care provider.

**Place a check mark on the line of each medication that you permit your child to receive.**

- \_\_\_\_\_ Acetaminophen (Tylenol) for pain, aches or fever
- \_\_\_\_\_ Advil (Ibuprofen) for pain, aches or fever
- \_\_\_\_\_ Benadryl -- allergy symptoms/allergic reaction
- \_\_\_\_\_ Cough Drop/Throat Lozenge – sore throat, cough
- \_\_\_\_\_ Hydrocortisone Cream – rash, stings, bites, itching
- \_\_\_\_\_ Icy Hot – sore muscles, aches, or cramps
- \_\_\_\_\_ Neosporin or Triple Antibiotic Ointment – cuts, scrapes, open sores
- \_\_\_\_\_ Tums – upset stomach, indigestion
- \_\_\_\_\_ Visine eye drops – redness, irritation, itching

**Dose:** per label                      **Frequency:** as needed

\_\_\_\_\_ I do **NOT** wish for my child to receive any over-the-counter medications.

I give permission for the medications noted above to be given to my child during school hours. I hereby release Glenforest School and their agents and employees from all liability that may result from my child taking these medications. I give permission for the school nurse or administrators to contact the health care provider named below to discuss these medications if a problem occurs. I understand that I am responsible for notifying the school of any change in my child's health.

**Is your child allergic to any food, medicines, or other items?** (please circle) **YES** or **NO** (if yes, please list allergies) \_\_\_\_\_

**Child's Health Care Provider's Name** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Parent or Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_