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** _____