CAPITAL
SCHOOL DISTRICT
198 Commerce Way
Dover, DE 19904

Permission for Use of Over-The-Counter Medications during the 2020-2021 School Year

Name of Student: _____ **Grade:** _____

Teacher's Name: _____

Does your child have allergies to any medication? **Yes**_____**No**_____

If yes, to what medicine? _____

As parent/guardian, I give my permission for the above named student to have the following medications administered by the school nurse during the current school year. I understand that he/she will be checked by the school nurse and the medications will be administered if indicated following the nurse's assessment. Please check only those medications you wish to be given to your child when needed.

_____ Advil / Ibuprofen / Motrin

_____ Anbesol/Orajel

_____ Anti-Fungal Cream

_____ Benadryl Liquid

_____ Benadryl Lotion (Anti-Itch)

_____ Burn Ointment/Spray

_____ Caladryl/Calamine Lotion

_____ Cough Drops

_____ Eye Wash Solution/Saline Rinse

_____ Hygiene Supplies

_____ Lip Ointment (Blistex/Chapstick)

_____ Skin Ointment (Bacitracin/ Hydrocortisone/ Neosporin)

_____ Sting Kill (Insect Sting Relief)

_____ Throat Spray (Chloraseptic Spray)

_____ Tums

_____ Tylenol / Acetaminophen

PARENT/GUARDIAN SIGNATURE:_____ Date:_____

Phone Number:_____

Revised 02/04/2020