



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

_____ Eye Wash Solution/Saline Rinse

_____ Anbesol/Orajel

_____ Hygiene Supplies

_____ Anti-Fungal Cream

_____ Lip Ointment (Blistex/Chapstick)

_____ Benadryl Liquid

_____ Skin Ointment (Bacitracin/ Hydrocortisone/
Neosporin)

_____ Benadryl Lotion (Anti-Itch)

_____ Sting Kill (Insect Sting Relief)

_____ Burn Ointment/Spray

_____ Throat Spray (Chloraseptic Spray)

_____ Caladryl/Calamine Lotion

_____ Tums

_____ Cough Drops

_____ Tylenol / Acetaminophen

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

Phone Number: _____

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