University Laboratory School

Authorization for the administration of over-the-counter medications

Student: _____ Grade: _____

Medical Condition(s)	Child's Daily Medication(s)

This form must be completed by the Parent/Guardian and signed by your physician or healthcare provider if you authorize administration of Over the Counter (OTC) medications

Please complete all sections. Circle **YES** or **NO** to indicate which of the approved list of OTC medications may be administered when the school nurse assessment indicates appropriate symptoms. All OTC medications will be administered according to the manufacturer's directions

OTC Medication	Condition/Symptom	Possible Side Effects	Alert
Acetaminophen (Tylenol) Yes No	Relief of minor aches and pains	Nausea, stomach pain, loss of appetite	Students with fever >100.4 will be sent home
Calcium Carbonate (TUMS) Yes No	Relief of mild stomach ache or heartburn	Constipation	Not to be used for children under 6 years
Hydrocortisone Cream Yes No	Temporary relief of itching from insect bites and stings	NONE	NONE
Ibuprofen (Motrin, Advil) Yes No	Relief of body aches & pain; Menstrual Cramps	Upset stomach	Not to be given to students with Aspirin allergy.
Lubricating Eye Drops Yes No	Relief of eye discomfort caused by irritation or dryness	NONE	Not to be used if eye drainage is present
Throat lozenge/cough drop Yes No	Relief of mild sore throat and/or cough	NONE	Not to be given to students under 6 years of age
Triple Antibiotic Ointment Yes No	Treatment of minor cuts and scrapes	NONE	NONE
Benzocaine/Menthol (Sting Relief) Yes No	Temporary relief of pain and itching from insect stings	NONE	NONE
Diphenhydramine (Benadryl) Yes No	Relief of hives, skin rash, itching or other allergy symptoms	Drowsiness, Constipation, Dry Mouth	Parent/Guardian will be notified if given
Benzalkonium (Burn Cream) Yes No	Relief of pain associated with minor burns, cuts, and scrapes	NONE	Not to be used on open wounds or blistered areas

I request the school nurse to assist my child in the administration of the above approved medication(s). I grant permission for my child to take the medications indicated above while at school by circling the "yes" according to the symptoms described. I release the school, and its health personnel, for civil damages and liability of loss resulting from compliance in good faith with this request and authorization. I understand these medications are stocked and maintained by the school nurse. My child's physician has provided his/her signature to serve as a medication order for the above parent approved OTC medication(s). I will be contacted if my child's symptoms do not improve and is unable to remain at school

I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel if required.

Parent/Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____

STUDENTS ARE NOT ALLOWED TO BRING OR CARRY ANY OVER THE COUNTER MEDICATIONS TO SCHOOL OR SCHOOL-SPONSORED EVENTS