



Over-the-Counter Medication Permission Form

Student's Name _____ Age _____ Birthday ___/___/___ Grade _____
(Last) (First) (MI)

The following medications may be available at your child's school. By placing an "X" in the box beside the medication(s) listed below, you are giving your consent for your child to receive the specified non-prescription/over-the-counter medication(s) on an "as needed" basis during the present academic year. Your consent authorizes the appropriate medication administration staff to administer to your child, any of the marked non-prescription/over-the-counter medication(s), in accordance with manufacturer and pediatric guidelines, as indicated by signs, symptoms, &/or complaints that your child may have. Parent/guardian will be contacted if temperature is ≥ 100.4 , if complaint continues, or if complaint increases after intervention.

NO (X)	YES (X)	I give my consent for my child to receive the following symptom-specific over-the-counter-medications if needed as marked "Yes"
<input type="radio"/>	<input type="radio"/>	<u>Advil or generic equivalent ibuprofen</u> <ul style="list-style-type: none"> • 5 to 10 years old: weight based to 100 pounds or 10 years old, every 6 hours as needed for headache, minor aches, pain • ≥ 10 years old and/or ≥ 100 pounds, 200 mg 1 to 2 tablets every 6 hours as needed for headache, minor aches, pain • ≥ 12 years old or ≥ 120 pounds: 200 mg 1 to 2 tablets every 6 hours as needed for headache, minor aches, pain
<input type="radio"/>	<input type="radio"/>	<u>Tylenol or generic equivalent acetaminophen</u> <ul style="list-style-type: none"> • 5 to 10 years old: weight based to 100 pounds or 10 years old, every 4 hours as needed for headache, minor aches, pain • ≥ 10 years old and/or ≥ 100 pounds: 650 mg every 4 hours as needed for headache, minor aches, pain • ≥ 12 years old or ≥ 120 pounds: 500 mg – 1000 mg every 4 hours as needed for headache, minor aches, pain
<input type="radio"/>	<input type="radio"/>	Tums or equivalent generic antacid with calcium carbonate 1 or 2 chewable tablets every 4 hours as needed for nausea, upset stomach
<input type="radio"/>	<input type="radio"/>	Caladryl or generic equivalent topical lotion every 4 hours as needed for skin irritations, itching
<input type="radio"/>	<input type="radio"/>	Carmex Lip Balm or generic equivalent apply sparingly ever 2 to 4 hours as needed for cold sores
<input type="radio"/>	<input type="radio"/>	Chapstick, Blistex Lip Balm, or generic equivalent every 4 hours as needed for chapped lips/lip irritation
<input type="radio"/>	<input type="radio"/>	Chloraseptic Lozenge or generic equivalent with phenol 1 every 2 hours as needed for sore throat pain
<input type="radio"/>	<input type="radio"/>	Cough Drop: Halls or generic equivalent cough drop 1 lozenge every 2 hours as needed for cough or throat irritation
<input type="radio"/>	<input type="radio"/>	Dermaplast Spray every 2 hours as needed for itching, minor burns, or insect bites
<input type="radio"/>	<input type="radio"/>	Eye Drops: Allergy Relief/Lubricating 1 or 2 drops every 2 to 4 hours as needed for eye irritation
<input type="radio"/>	<input type="radio"/>	Eye Drops: Rewetting 1 or 2 drops every 2 to 4 hours as needed for contact lens discomfort or eye irritation
<input type="radio"/>	<input type="radio"/>	Hydrocortisone Topical Cream 1" or generic equivalent every 4 hours as needed for skin irritations, itching
<input type="radio"/>	<input type="radio"/>	Hydrogen Peroxide (1/2 strength) 2 times/day as needed for wound cleansing, use for 1 to 2 days only
<input type="radio"/>	<input type="radio"/>	Lotion: Vaseline Intensive Care or generic equivalent topical every 4 hours as needed for chapped or irritated skin
<input type="radio"/>	<input type="radio"/>	Oragel or generic equivalent every 1 hour as needed for minor mouth pain
<input type="radio"/>	<input type="radio"/>	Polysporin or generic equivalent antibiotic ointment 4 times a day as needed for minor cuts, abrasions
<input type="radio"/>	<input type="radio"/>	Sterile Saline Solution as needed for contact lens care
<input type="radio"/>	<input type="radio"/>	Vaseline Petroleum Jelly or generic equivalent topical every 4 hours as needed for lip or minor skin irritation
<input type="radio"/>	<input type="radio"/>	FOR URGENT/ACUTE USE ONLY: <u>Benedryl or generic equivalent diphenhydramine liquid</u> (12.5 mg per 1 teaspoon) <ul style="list-style-type: none"> • Children 6 to 12 years (48-95 pounds) 1 or 2 teaspoons every 4 hours as needed for hypersensitivity reaction symptoms as per OCS Hypersensitivity Reaction Protocol • Children ≥ 12 years (≥ 96 pounds) 2 or 4 teaspoons every 4 hours as needed for hypersensitivity reaction symptoms as per OCS Hypersensitivity Reaction Protocol

LIABILITY RELEASE: In case of medical or surgical emergency, I/we hereby request and give permission to the staff at St. Paul Catholic School for the hospitalization and/or provision of necessary medical treatment for the above-named child. I/We understand that depending upon the seriousness of the above-named child's situation/injury, 911 may be contacted & he/she may be transported to the nearest hospital. I/We understand that I/we will be contacted immediately in the case of an emergency to my child. I/We understand that if there are any changes to any information (i.e., contact information, insurance policy, medical conditions, medications, court orders, etc.), that is my responsibility to keep my child's school records updated and will report any changes to my child's School Office at once. I hereby agree to the terms listed on this document and release and hold the medication administration staff in the St. Paul Catholic School and St. Paul staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from administration of the medications listed above that I have marked "YES."

Parent/Guardian Signature

Date