



Over-the-Counter Medications Form

Students Name: _____ DOB: _____ YOG: _____

Medication allergies:

List any medications your child receives regularly:

I give permission for my child _____ to receive any medication I have indicated below as deemed necessary by the school nurse. I understand the generic equivalent may be used in place of more expensive name brands.

PLEASE CHECK ANY OVER-THE-COUNTER MEDICATIONS YOU WISH TO BE MADE AVAILABLE TO YOUR CHILD UNDER NURSING DISCRETION. DOSAGE DETERMINED BY AGE AND/OR WEIGHT.

For headache/fever/muscle aches/menstrual cramps:

- Acetaminophen (like Tylenol)
- Ibuprofen (like Advil, Motrin) – best for menstrual cramps, muscle/bone pain.

For mild allergic reactions (such as hives):

- Benadryl (Diphenhydramine)

For mild cold symptoms:

- Sudafed throat lozenges/cough drops Robitussin DM

For mild stomach discomfort:

- Antacid

For mild skin irritation (poison ivy, insect bites, minor rashes):

- Calamine lotion Hydrocortisone cream 1%

I do not want any medication to be given to my child in school.

I understand that the above medications I have checked will be administered by the school nurse in accordance with established protocols endorsed by the medical consultant physician.

Parent/Guardian Signature

Date

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