Permission for Over-The-Counter Medications

Providence Day School

Parent or guardian signature required

Student Name Date of Birth

Parent Name

If you would like for your child to receive over-the-counter medication during the school day the form below must be completed and signed by your child's physician and returned. This form is only for the medications listed below and will only be administered per manufacturer's recommended dosing. This form will remain in effect for the entire school year.

☐ **All Over-The-Counter Medications Below**
☐ **No Over-The-Counter Medications Below (only parent signature required)**

Or *indicate which medications may be administered by checking the boxes below:*

☐ Acetaminophen (generic for Tylenol)
☐ Ibuprofen (generic for Motrin/Advil)
☐ Benadryl (antihistamine)
☐ Antacid (generic for children's Mylanta/Tums)
☐ Allergy eye drops
☐ Bacitracin ointment
☐ Benadryl cream
☐ Hydrocortisone cream

Please list **all Over-the-Counter medications with their dosages your child takes on a regular basis at home (including all allergy medicine, nasal sprays, vitamins or supplements), _____

_____

I give permission for the school nurse to dispense the above checked over-the-counter medicine(s) to my child:

Parent Signature Date

Physician's Signature or Stamp : Date Physician's telephone: