Consent for Administration of Over the Counter Medications 2016-2017

St. Stephen School: School phone 410-592-7617 /Fax 410-592-7330

Good for 2016-2017 school year only. Must be renewed each school year.

Student Name: ____________________________ Grade: ____________

Known Allergies:

List any long-term medication your child receives:

I give permission for my child _________________________ to receive the medications checked below on this form by the School Nurse when appropriate. I understand that generic equivalent medications may be used. I understand that this form must be signed by my child’s physician.

Please check any medication(s) you wish to be made available to your child under nursing discretion:

For Headache/Fever/Earache/Muscle Aches/Pain/Menstrual Cramps

_______Acetaminophen (like Tylenol) < 12 years, 10 mg/kg, PO Q 4-6 hours as needed
12 years or older 325-650 mg, PO Q 4-6 hours as needed.

_______Ibuprofen (like Advil/Motrin) < 12 years, 5mg/kg, PO Q 6-8 hours as needed
12 years and older, 200 mg, PO Q 4-6 hours as needed.

For Mild Allergic Reaction

_______Diphenhydramine (like Benadryl) 12.5mg. PO Q 4-6 hours as needed
12 years or older, 25-50 mg, PO Q 4-6 hours as needed.

For Coughs/Sore Throats (Mild) For Mild Upset Stomach

_______Cough Drops 1 or 2 ____Chewable Antacid Tabs 1 or 2 (Tums)

For Itching due to skin irritations (like Poison Ivy)

_______ Calamine Lotion

_______ I DO NOT wish to utilize the Over the Counter Medications for my child.

Parent/Guardian Signature                      Date

________________________________________________________________________

PHYSICIAN’S SIGNATURE                      Date                      Office Number