Consent for Administration of Over the Counter Medications 2023-2024

Good for 2023-2024 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)  

__________ Cough Drops 1 or 2  

For Mild Upset Stomach

__________ 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