St. Joseph School - Fullerton
Consent for Administration of Over the Counter Medications

Good for_____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:

****** Child's Current Weight:_____**

For Mild Allergic Reaction

_____Diphenhydramine (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 Headache/Fever/Earache/Muscle Aches/Pain/Menstrual Cramps

_____Acetaminophen (like Tylenol), dosage 10 mg/kg, PO Q 4-6 hours as needed

_____Ibuprofen (like Advil/Motrin), dosage 10 mg/kg, PO Q 6-8 hours as needed

For Coughs/Sore Throats (Mild)

_____Cough Drops 1 or 2

For Mild Upset Stomach

____Chewable Antacid Tabs 1 (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:_____

Physicians Signature:_____

*******Parents must provide medication to school Nurse labeled with their name and homeroom. All medications must be hand delivered to the School Nurse by an adult, not sent in with student.*******