ST. JOSEPH SCHOOL
FULLERTON

Phone: _____Fax: _____

CONSENT FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATIONS for School Year_____
(Must be renewed each year.)

Student's Name: _____ Grade: _____Date of Birth:_____

Weight: _____lbs._____kg (if needed for dosage) Allergies: _____

Medication currently receiving: _____

Parents/guardians must provide medication to School Nurse in the original, unopened container labeled with their student's name and homeroom. All medications must be hand delivered to the School Nurse by an adult, not sent in with student.

Check all medications that may be given and specify dose and frequency in the chart below. If you prefer that no over-the-counter medications be administered to your child at school, please check the box below.

	Medication	Reason	Dose	Route	Frequency	Side Effects
☐	Ibuprofen/Motrin					
☐	Acetaminophen/Tylenol					
☐	Dephenhydramine/Benadryl					
☐	Antacid Tablets/Tums					
☐	Cough Drops					
☐	Antibiotic Ointment					
☐	Anti-itch Lotion/Cream (Hydrocortisone, Calamine)					
☐	Aquaphor, Eucerin					

Note any special instructions for medications to be given (e.g. take with food):

_____

_____

Please note School policy does not permit the student to self-carry the over-the-counter medications.

☐ I do not wish my child to receive any over-the-counter medications at school. (No Doctor's Signature is required.)

Parent/Guardian Signature: _____Date: _____ Phone: _____ Doctor's Signature: _____Date: _____ Phone:_____

School Nurse Signature: _____Date:_____Phone:_____