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 daily or as needed medication(s) 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, 25-50mg PO Q 4-6 hours as needed

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

_____Acetaminophen (like Tylenol), Dosage 10mg/kg, PO Q4-6 hours as needed

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

For cough/Sore Throats (mild)

_____ Cough Drops 1 or 2

For Mild Upset Stomach

_____Chewable Antacid Tabs 1 (TUMS)

_____**I DO NOT wish for my child to have Over the Counter Medications at school.**

Parent 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.*****