OVER-THE-COUNTER TREATMENT CONSENT FORM

Dear Parents,
There are times when over the counter medications may be appropriate to relieve mild pain (such as a headache, toothache, or cramps), skin abrasions, temporary relief of itching due to skin irritation or for a mild allergic reaction so that a child may return to his/her school work. We would like your permission to give any of the following medications in school when such an occasion occurs. If you do not wish your child to be given over the counter medication please check off on the appropriate line below.

Here is a list of medications that we will be utilizing in the health care office. Please check those medications your child may receive and sign on the parent/guardian line.

For headache/minor pain:

______Tylenol/acetaminophen

______Ibuprofen/Advil/Motrin

For sour stomach, acid indigestion/heartburn:

______Tums

For cold/allergy symptoms:

______Benadryl/diphenhydramine: (hives, insect bites, allergy).
______Throat Lozenges

Other topical products:

______ Bacitracin/Neosporin (ointment): for skin abrasions and/or skin lacerations.
______ Hydrocortisone 1%(cream/ointment): for temporary relief of itching associated with minor skin irritation and/or rash.
______ Sunscreen
______ Calamine or Calagel Lotion
______ Aloe Vera soothing gel to relieve sunburn.
*All medications dosages are given per label instructions by age and weight.

______ I do not give consent for the administration of over the counter medication to my child.

Name of Child:_____________________________________ Grade: _______________

Signature of Parent/Guardian: ___________________________________ Date: _______________

Is there any reason why your child should not receive Tylenol or Motrin?________

- Is your child allergic to Tylenol or Motrin? YES_____ NO_____
- Does your child have a history of liver disease? YES______ NO_____
- Does your child have nasal polyps? YES _____ NO ______
- Does your child have a history of a bleeding disorder? YES _____ NO _____
- Does your child gastrointestinal disorders? YES _____ NO ______

Drug/Food Allergies ____

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Important: Consent for Treatment/Transfer/Screening

Parent/Guardian Authorization: I hereby give permission to the school to provide routine health care, administer prescribed medication, provide health care screenings (BMI, height, weight, hearing, vision and postural), and seek emergency medical treatment. In the event I cannot be reached in an emergency, I hereby give permission to the school health care team to secure and administer treatment, including hospitalization, for the person named above.

Signature of Parent/Guardian:_________________________________ Date: ___________