_____ SCHOOL DISTRICT

SCHOOL HEALTH SERVICES

PERMISSION TO ADMINISTER MEDICATION

Student's Name (please print) | **Grade** | **Date of Birth**

Dear Parent or Guardian:
The school nurse has standing orders from the Region III Medical Director to certain nonprescription medications. These will be given per the District Physician's instruction with a Parent signed permission form on file.

OVER THE COUNTER MEDICATIONS

YES	NO	
		To **ALL** the medications listed below. _____ Parent initials

If **NO**, please Indicate below which medications, if any, we may give your child.

YES	NO	MEDICATION NAME & USAGE
		Antibiotic Ointment/Triple Antibiotic Ointment-temporarily protecting minor cuts, scrapes
		Anti-Itch Topical Ointment-Relief for minor insect bites or minor skin irritation
		Oral Numbing Gel (Benzocaine 10% or less)-Temporary relief for mouth or tooth pain
		Aloe Vera Gel-Soothe 1st degree sunburns and burns with intact blisters/Itch relief of insect bites or rashes
		Aquaphor/White Petroleum/Vaseline-Temporarily protecting and relieving chapped or cracked lips or skin/Temporarily protecting minor cuts, scrapes, and burns
		Contact Solution/Sterile Ophthalmic Irrigation Solution-For use with contact issues
		Bactine First Aid Antiseptic-For minor skin infections caused by small cuts, scrapes, and burns
		Saline Eye Wash-Relief of eye irritation/Irrigate affected eye
		Caladryl/Benadryl / Anti-Itch Ointment-For relief of itching due to mild poison ivy-oak, insect bites, or other minor skin irritations/Oral Benadryl for mild Allergic Reactions
		Chloraseptic Mouth Spray-Relief of mild sore throats
		Tylenol / Acetaminophen for fever greater than 100.0, headache or pain
		Advil / Motrin / Ibuprofen for fever greater than 100.0, headache or pain

Be advised that the School District Medication Guidelines discourage giving medication during school hours unless deemed necessary. **It is strongly advised that non-prescription medicine be given before or after school.**

PARENT/GUARDIAN CONSENT

I give my permission for my child to receive the above medications during the school day upon their request and release the _____ School District and its employees from liability for any damages my child may suffer as a result of this request. I understand that the medications will be given by a school nurse, substitute nurse or principal designated staff according to the district physician's standing orders. I understand that the use of any of the above medications is limited to three doses in one month and a doctor's evaluation and medication order may be required if my child needs to take medication more frequently.

Parent/Guardian Signature | **Date**