

PERMISSION FOR NON-PRESCRIPTION MEDICATION

Dear Parent/Guardian,

The form below must be read, filled out and signed by **parents and physician** for the school nurse, volunteer school nurse, or staff member to administer medication to your student. In order to protect the health and welfare of the students and school staff, Indiana laws require parent's written consent to administer medications.

1. **The school nurse will have a limited supply of non-prescription (over-the-counter) medications. These medications will be given sparingly.**
2. **Non-prescription medication will only be given as instructed on the brand label, unless the school receives a written order from a physician authorizing the change. Only the school nurse can take a physician order over the phone or by fax.**
3. **For a non-prescription medication *that is not listed below*, you will need to obtain a physician's order and bring the order and the medication to the school nurse's office.**
4. **Medication brought to the school must be kept in the nurse's office in a locked cabinet. The medication must be in the original UNOPENED container with an outside label including the name of the medication, the use for the medication and the age appropriate dose to be given. Please write your child's name and date on the container.**

Name of Student _____ Grade _____ Date of Birth _____

My son/daughter may receive the medications checked below.

Yes	No	Medication	Dosage	Frequency
___	___	Tylenol (Acetaminophen)	per package instructions	as needed for headache, minor pain
___	___	Motrin/Advil (Ibuprofen)	per package instructions	as needed for headache, minor pain
___	___	Benadryl	per package instructions	Bee/Insect sting, allergic reaction
___	___	Menthol Throat Lozenge	per package instructions	as needed for sore throat or cough
___	___	Mylanta/Tums Tablets	per package instructions	as needed for minor upset stomach
___	___	Saline eye drops	1 or 2 drops	as needed for itchy eyes or to dislodge debris
___	___	Hydrogen Peroxide	per package instructions	as needed for minor abrasions
___	___	Antibiotic Ointment	per package instructions	as needed for minor abrasions
___	___	Caladryl	per package instructions	as needed for itchy skin/itchy bites
___	___	Vaseline	per package instructions	as needed for dry or cracked lips
___	___	Sting Kill	per package instructions	as needed for bee/insect sting
___	___	Orajel	per package instructions	as needed for minor mouth sore
___	___	Burn Jel	per package instructions	as needed for minor burns

Please Note: Generic brands are used in most cases.

I authorize my patient to take the following additional non-prescription medication as needed during school hours.

<i>Medication</i>	<i>Dose</i>	<i>Frequency</i>
Reason for Medication _____		

Physicians Signature _____ *Date* _____

I authorize the St. Maria Goretti School nurse or school personnel under the supervision of the school nurse to be my agent to give medications checked above to my child.

Parent/Guardian signature _____ Date _____