CONSENT FOR ADMINISTRATION OF "OVER-THE-COUNTER" MEDICATIONS

Student's Name ____ Grade____________

Medication or Food Allergies ____

List medications your child receives regularly____

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Please check any medication(s) you wish to be made available to your child under nursing discretion:

For headaches/fever/muscle aches:

( ) **Acetaminophen** (like *Tylenol*) 1 or 2 - 500mg tabs every 4-6 hours

( ) **Ibuprofen** (like *Advil, Motrin*) 1 or 2 – 200mg tabs every 4-6 hours

For mild cold symptoms:

( ) **Cough Drop** 1 or 2 for mild throat discomfort, mild cough

For mild stomach discomfort:

( ) **Antacid** (*Tums* or generic equivalent) 2 tabs

For mild skin irritation: Topical medications

( ) **Hydrocortisone Cream** 1% - for minor skin irritations and rashes due to dermatitis, poison ivy/oak, insect bites

( ) **Antibiotic Ointment** (like *Bacitracin, Neosporin*) – for minor cuts/abrasions

( ) I DO NOT WANT ANY MEDICATION TO BE GIVEN TO MY CHILD AT SCHOOL.

This form will be good for your student's entire tenure at Archbishop Curley High School.

I understand that any of the above checked medications will be administered by the school nurse in accordance with the established protocols endorsed by the school physician.

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Signature of Parent/Guardian Date