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

Student's Name _____ Grade_____

Medication or Food Allergies _____

List medications your child receives regularly_____

_____

_____

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.

_____ _____

Signature of Parent/Guardian Date