School Year:_____

Consent for Over-the-Counter Medication Administration

Student Name_____ Date of Birth_____ Grade_____

I consent for the School Health Professionals of Robinson CUSD #2 to treat my child if deemed necessary or advisable based on his/her presentation to the School Nurse Office. It is recognized that minor symptoms occur that may not be relieved through comfort care. The School Health Professional does have certain over-the-counter medications in stock which can be administered if authorized by the parent on this form. Before granting school permission to administer over-the-counter medication, please check with your doctor/pharmacist that the medications below do not interact with any medications your child may already be taking.

_____ No, my child may not be given any over-the-counter medications or options listed below. I understand that only comfort care measures (such as an ice pack/rest) will be administered until I am contacted.

_____ Yes, my child may see the School Health Professional and receive the over-the-counter medications indicated below if deemed appropriate based on his/her presentation and symptoms. I have checked with his/her physician/pharmacist to verify the safety with other medication.

- Acetaminophen (Tylenol)
- Ibuprofen (Motrin/Advil)
- Benadryl antihistamine (for generalized allergic reaction)
- Artificial tear solution
- Hydrocortisone cream/Caladryl (topical itching/rash)
- Tums/antacid/Pepto
- Cough Drops (menthol, i.e. Halls)
- Triple antibiotic ointment
- Oragel/Campho-phenique
- Sunscreen/Aloe

MEDICATION HISTORY:

Is your student allergic to any medication? _____

If yes, please list medicine(s) and type of reaction:

_____

Does your student take any medication on a regular basis? _____

If yes, please list and provide medication authorization form from your child's physician:

_____

Parent/Guardian Signature _____ Date _____