Consent & Authorization for School to Give Non-Prescription Medications at School

Name of Student: _____ **Birthdate:**_____ **School:** _____ **Grade:**_____

Any Known Allergies? (List): _____

BY COMPLETING AND SIGNING THIS FORM YOU ARE AUTHORIZING YOUR CHILD TO TAKE THE OVER THE COUNTER MEDICATIONS INDICATED WITHOUT FURTHER NOTIFICATION FROM THE SCHOOL PRIOR TO THE STUDENT RECEIVING THE MEDICATION.

Use of Over the Counter Medications at School

I hereby authorize the Dodgeville School District to give medication(s) to my child according to the directions listed, and give the school consent to contact my child's physician. I agree to hold the Dodgeville School District, its employees, and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school. I also agree to inform the school immediately in writing of any change in the medical order.

I will supply limited quantities of the medication in the original container labeled properly with the child's full name, name of the drug, dosage of the drug, time, quantity to be given, and physician's name.

CIRCLE yes or no for all medications that This Student May Receive at school including Oral Medications, Topical Medications, or other substances listed below. Dosage will be as recommended on the label for student weight or age.

Yes	**No**	Triple Antibiotic Ointment topically as needed to minor skin wounds or sores
Yes	**No**	Hydrocortisone Cream 1% topically as needed for minor bug bites, skin itching/inflammation or rash
Yes	**No**	Oragel or benzocaine 10% gel topically as needed for dental pain or sores in mouth or on lips
Yes	**No**	Benadryl or diphenhydramine orally as needed for symptoms of allergic reaction (usual dose: ages 6-12 is 12.5 mg to 25 mg; ages 12 to adult is 25 mg to 50 mg)
Yes	**No**	Tylenol or acetaminophen for pain or headache one dose every 4 hours as needed for headache, fever, earache, menstrual cramps, upper respiratory conditions, minor sprains/strains, or minor discomfort using the Recommended Pediatric Dosing Chart; do not exceed 5 doses in 24 hours
Yes	**No**	Advil or ibuprofen for pain or headache one dose every 4 hours as needed for headache, fever, earache, menstrual cramps, upper respiratory conditions, minor sprains/strains, or minor discomfort using the Recommended Pediatric Dosing Chart; do not exceed 4 doses in 24 hours
Yes	**No**	TUMS, antacid tablets, antacid liquids as needed for stomach pain or upset
Yes	**No**	Excedrin Migraine or generic equivalent as needed for onset or occurrence of migraine or migraine like headache
Yes	**No**	Sunscreen (generic brand) or parent provided sunscreen
Yes	**No**	Insect Repellent that is herbal based or parent provided brand

_____ _____ _____ _____

Signature of Parent/Legal Guardian **Date** **School Nurse** **Date**

FORM MUST BE SIGNED BY PARENT OR LEGAL GUARDIAN BEFORE MEDICATION WILL BE GIVEN TO THE STUDENT AT SCHOOL.

Revised 06.11.2019 aej

RECORD OF OVER THE COUNTER MEDICATION GIVEN

Name of Student _____ Grade _____ School Year:

Date	Time Given	Medication Name/Dosage	Amount Given	Reason Given	Signature of Person Giving