**Over-the-counter (OTC) medication**

**GRADES 6-12 only**

Student’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade\_\_\_\_\_\_\_\_\_\_

I give permission to the school nurse to administer any of the following OTC medications to my child according to the protocol noted below. I understand this order needs to be filled out every school year and that all other medications require a written doctor’s order with written parent consent. I realize the school nurse may limit usage and may contact me requesting medical attention as appropriate.

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| --- | --- |
| **Acetaminophen (Tylenol)**  **325 mg** | 1-2 tablets, orally, as needed for headache, menstrual discomfort, tooth discomfort, or earache |
| **Cough drop/oral anesthetic** | 1-2 drops, orally, as needed for cough or sore throat |
| **Calcium Antacid (Tums) 500 mg** | 1-2 tablets, orally, as needed for stomachache/indigestion |
| **Bacitracin-zinc ointment** | Topically, as needed for cut/abrasion or superficial burn |

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Christine Sickle, MD Date

School Physician Consultant

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Nurse Leader

*My child has taken the above medications at home and has had no allergic reactions. I will contact the school nurse if any concerns arise.*

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Parent signature Date