CENTRAL COMMUNITY SCHOOL DISTRICT

AUTHORIZATION FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATIONS

Student Name:	Birth Date:	Medication Allergy	Grade:	School Year:

Parent/Guardian:	Address:
Medical Conditions:	Please list all medications your child takes:

Home Phone:	Cell Phone:	Emergency Contact:

Action Plan: (To be completed by parent/guardian). Please complete all sections. Check yes or no to indicate which of the approved list of over the counter medications that may be administered when school nurse's assessment indicates symptoms appropriate. All over the counter medications will be administered according to manufacturer's directions.

OTC Med	Condition/Symptom	Possible Side Effects:	Comments:
Acetaminophen (Tylenol) ☐ Yes No ☐	Relief of minor aches & pain, fever >100.4 will not be treated at school.	None	Alert: Students with fever >100.4 must be sent home from school
Calcium Carbonate (Tums) ☐ Yes No ☐	Relief of mild stomach ache or heart burn	Constipation	Alert: Not to be used in children under 6 yrs old
Ibuprophen (Advil, Motrin) ☐ Yes No ☐	Relief of body aches & pain, menstrual cramps: Fever >100.4 will not be treated at school	Stomach upset	Alert: Contains no aspirin (salicylates), but should not be given if student has allergy to Aspirin: may cause stomach bleeding
Throat lozenge/Cough Drop ☐ Yes No ☐	Relief of mild sore throat and/or cough	None	Alert: Not for use in children under age 4.
Triple antibiotic ointment ☐ Yes No ☐	Treatment of minor cuts and scrapes	None	None
Hydrocortisone Cream ☐ Yes No ☐	Temporary relief of itching caused by insect bites and stings	None	None
Lip Balm ☐ Yes No ☐	Relief of dry/chapped lips	None	None
Lubricating eye drops ☐ Yes No ☐	Relief of eye discomfort caused by irritation.	None	Alert: Not to be used if eye drainage is present.

PARENTAL PERMISSION (To be completed by Parent/Guardian) Form is void if this section is incomplete

I request the school nurse to assist my child in the administration of the above described medication(s). I give permission for my child to take the medication indicated above while at school by my checking the yes box according to the symptoms described. I understand that there is: (1) no liability on the part of the school district, it's personnel, or agents, including physician providing standing orders, for civil damages as the result of the administration of this medication to my child (2) these medications are stocked and maintained by the school clinic with standing orders provided by a local physician, (3) I will be contacted if my child's symptoms do not improve and is unable to remain at school.

I hereby authorize the exchange of medical information regarding by child's treatment plan between the physician and school health personnel of Central Community School District.

Parent/Guardian Signature: _____ Date: _____

STUDENTS ARE NOT ALLOWED TO BRING OR CARRY ANY OVER THE COUNTER MEDICATIONS TO SCHOOL OR SCHOOL SPONSORED ACTIVITIES.