Clinton School District

Administration of Non-Prescription Medications to Students

(Permission form for school administered medication)

Student Name: _____Grade:_____

ALLERGIES (medication or other): Please list: _____

Please check which of the following over-the-counter (OTC) medications, supplied by the Clinton School District, that your student may be given in the nurse's office. These medications are given as directed on the package.

___**Tylenol** or generic acetaminophen for pain or elevated temperature

___ **Motrin** or Ibuprofen for pain or elevated temperature

___ **Cough drops** or sore throat lozenges for cough or sore throat

___ **Tums** or generic anti-acid tablets for upset stomach

___**Caladryl** or generic anti-itch lotion for rash or bug bites

___ **Aloe Vera Gel** or generic for minor burns/stings

___ **Neosporin** or generic antibiotic ointment for abrasions

___ **Visine (saline drops)** or generic eye drops for irritated eye

___**Chloraseptic** throat spray or generic brand for sore throat

___ **Hydrocortisone** cream or generic brand for minor skin irritation, itching

___**Benadryl** tablets or liquid for hives, allergic reactions or allergy symptoms

___ **Chapstick** or Vaseline for chapped lips

___ **Ora-gel** or generic for toothache.

The School District provides the following treatment if needed for **LIFE THREATENING ALLERGIC REACTIONS OR LIFE THREATENING ASTHMA SYMPTOMS: Epi-Pen Jr. 0.15mg** or **Epi-Pen Adult 0.03mg** for severe life threatening allergic reaction or **Albuterol** Sulfate Inhalation Solution per nebulizer treatment for life threatening Respiratory Distress.

I give permission for school health personnel and his/her designee to administer the above medications to my student as needed. This consent form is good for the entire duration my student is enrolled in the Clinton School District. As the parent/guardian I will come to the school and note changes to this form if needed in the future.

_____ _____ _____

(Parent or Legal Guardian Signature) (Contact Number) (Date)

*****If your student requires any of the above medication on a routine basis, the parent will supply the medication to the school. **All medication must be brought to and from school by an adult. This medication will be brought in a new bottle with the safety seal intact. Open bottles/containers will NOT be accepted.**