



**ELIZABETH SCHOOL DISTRICT
NON-PRESCRIPTION MEDICATIONS
PERMISSION FORM: 20_____ - 20_____**
New forms must be completed every year

Student Name: _____ DOB: _____ School: _____

Over-the-counter (OTC) medications are drugs that do not require a prescription and are purchased "over-the-counter". This form is required before OTC medications can be administered at school. Exceptions to this are homeopathic/herbal medications and OTCs not included in this list, which require completing the form "**Permission to Give Prescription/Homeopathic Medication at School**".

Please initial or check each over-the-counter medication for which you give your permission for your child to have at school, then sign below.

_____ **I approve all medications listed below**

Oral:

_____ **Acetaminophen** (Tylenol or generic substitute)
_____ **Benadryl** (Diphenhydramine)
_____ **Claritin** (Loratadine)
_____ **Cough Syrup** (Delsym/Robitussin)
_____ **Ibuprofen** (Motrin, Advil or generic substitute)
_____ **Throat Lozenges**
_____ **Tums** (Calcium Carbonate)
_____ **Zyrtec** (Cetirizine Hydrochloride)

Topical:

_____ **Antibiotic Cream** (Bacitracin)
_____ **Benadryl Cream**
_____ **Burn Gel** (Lidocaine)
_____ **Contact Solution**
_____ **Saline Eye Solution**
_____ **Sunscreen**
_____ **Unscented Lotion**
_____ **Vaseline** (Petroleum Jelly)

_____ **I do not want *any* OTC meds given to my student**

If this form is not returned to school, your child will not be given these medications. Please indicate if your child has an allergy or an unusual or unpleasant side effect to a specific generic or brand name medication. Please contact your school's health office with questions.

Allergies/side effects:

Additional comments:

I/we attest that I/we have a standing medical order from the student's healthcare provider that authorizes the administration of the above identified over-the-counter medications during the school year by the school nurse or nurse's designee.

It is understood that the medication is given solely at the request of, and as an accommodation to, the undersigned parent(s) or guardian(s). The undersigned parent(s)/guardian(s) hereby agree(s) to exempt and release the Elizabeth School District, its directors, officers, employees, volunteers, and agents from any and all liability, claims, demands or actions arising out of any damage, loss, or injury that my child or I/we sustain arising out of the administration of the non-prescription medication identified above to my child.

I have carefully read the information above and hereby authorize the school nurse or designee to administer the above medications during the current school year.

Signature of Parent/Guardian: _____ Date: _____

Name of Parent/Guardian: _____