ELIZABETH SCHOOL DISTRICT
NON-PRESCRIPTION MEDICATIONS
PERMISSION FORM: 20_____ - 20_____

Student Name: _____ DOB: _____ School: _____

This form is required before over-the-counter medications can be administered at school. No medication will be given unless absolutely necessary, at the discretion of the school nurse or nurse's designee. This form needs to be completed each school year.

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.

	Yes	No
1. Acetaminophen Regular Strength (Tylenol or generic substitute) (you may be asked to pick up your child if the problem persists or if your child has a fever of 101 or above)	_____	_____
2. Antibiotic Ointment or cream (Neosporin or generic substitute)	_____	_____
3. Oral Diphenhydramine (Benadryl or generic substitute for allergy or common cold symptoms)	_____	_____
4. Topical Benadryl or Hydrocortisone cream or generic substitute	_____	_____
5. Calcium Carbonate (Tums or generic substitute)	_____	_____
6. Ibuprofen (Advil, Motrin or generic substitute) (you may be asked to pick up your child if the problem persists or if your child has a fever of 101 or above)	_____	_____
7. Saline Eye Drops (Liquid Tears or generic substitute)	_____	_____
8. Cough drops (**Only ages 6 and older**)	_____	_____

Dosages will be determined according to manufacturer's recommendations. **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: _____