PERMISSION TO GIVE MEDICATION

Student Name_____

The following medications may be given on an as needed basis after assessment by the school nurse if there are no contraindications or allergies and with parental consent. Medications will be administered as directed by the manufacturer.

Please draw a line through any of the following medications that you do not want used in the treatment of your child.

NON-ASPIRIN PAIN RELIEVER (Acetaminophen, Tylenol for pain or fever)

ANTI-INFLAMMATORY PAIN RELIEVER (Ibuprofen, Advil for pain or fever)

THROAT LOZENGE (Chloraseptic or generic)

COUGH DROP (cherry eucalyptus menthol)

TUMS, GELUSIL or ANTI-GAS LIQUID (heartburn, acid indigestion, gas, sour stomach)

ORA-JEL or generic or CLOVE OIL (Mouth or tooth irritations)

BLISTEX or VASELINE (chapped lips)

BENADRYL or generic (Allergic reactions or congestion)

DECONGESTANT (Phenylephrine, generic Sudafed PE)

COLD RELIEF TABS (Multi symptom: acetaminophen, dextromethorphan, guaifenesin, and phenylephrine)

STING RELIEF (Insect stings or bites)

SWIM- EAR (Ear drying aid, isopropyl alcohol)

HYPO TEARS, EYE WASH OR CONTACT LENSE SOLUTION (Minor eye irritations, contacts)

BACITRACIN (Antibiotic ointment for minor cuts and wounds)

HYDROGEN PEROXIDE OR SALINE SOLUTION (cleanse for minor cuts and wounds)

CALADRYL / BENADRYL CREAM (Minor skin irritations or rashes)

ANTI- ITCH CREAM/ HYDROCORTISONE CREAM (Minor rashes or irritation)

BURN GEL

SUNSCREEN may self-apply and self-carry at teacher/nurse discretion

EPINEPHRINE AUTOINJECTOR (given only for life threatening allergic reaction)

I authorize the use of the above, unless crossed out, for my child.

Signature of parent/guardian_____ Date_____

Authorization will be in effect from August 28th, 2024 until September 30th, 2025.