



2025-2026 School

Permission to Administer Over the Counter and Prescription Medications

Valid for all school sponsored day, after school or overnight activities.

This Form Can Be Replaced with OTC Permission List from Physician

****Cross off any preparations that you do not want your child/patient to receive****

A Separate Physician Order is Required for Prescription Medications

Child's Name: _____ **DOB:** _____ **Grade:** _____ **School Year:** _____

Medication Allergies: _____

Vaseline Petroleum Jelly/Aquaphor/Lip Balm for chapped skin or lips

Aloe Gel or Cream for a minor skin irritation

Unscented hand and body moisturizing lotion

Calamine/Caladryl/Anti-itch gel or lotion for an itchy rash or insect bite

Bactrim spray/Isopropyl Alcohol/Hydrogen Peroxide as antiseptic

Bacitracin ointment for a minor skin wound

Sunscreen to prevent sunburn (supplied from home)

Tums or Mylanta for indigestion

Cough drops for sore throat/cough in a child with a good cough and swallow reflex

Acetaminophen 325mg tab or 160mg per tsp (dose per age/weight)

Ibuprofen 200mg tab or 100 mg per tsp (dose per age/weight)

Benadryl 12.5mg per tsp or 25mg tab (1-2 tsp or 1-2 tabs every 6 hrs. for allergic reaction)

Other:

PRESCRIPTION MEDICATIONS:

Physician please check if applicable:

☐ If morning dose is not given at home, nurse may administer dose of _____ with verbal or written notification from parent.

☐ I assess this child to be self-directed and ☐ may self-carry medication.

I give permission for my child/patient to use the over the counter preparations and prescription medications listed above. I have crossed out the items that they may not have/use. Administration of over the counter medications will be "per label" directions for age/weight unless otherwise indicated by provider.

Parent signature

Daytime Phone

Date

Physician Name

Phone Number

Physician Signature

Date