School Year: 20____ - 20____
New forms must be completed every year.

USD 261 HAYSVILLE SCHOOLS

Permission to Administer Over-the-Counter Medication
Haysville Public Schools
Health Service Department

Student Name: _____ Date of Birth: _____ Grade: _____

Board Policy:

OVER-THE-COUNTER (OTC) MEDICATION WILL BE GIVEN AT SCHOOL ONLY UPON WRITTEN REQUEST FROM THE LAWFUL GUARDIAN. THIS WRITTEN REQUEST IS REQUIRED BEFORE ADMINISTRATION OF MEDICATION IS INITIATED.

OTC medications must be provided by the guardian in the original container and will be given per label instructions unless otherwise indicated by a physician. Additionally, the student must have taken the OTC medication previously without adverse reaction. OTC medications that will require a physician order include homeopathic/herbal medications and aspirin (or medications containing aspirin). All OTC medications will be given on an as needed basis and a physician order will be needed if the medication is needed daily (scheduled). These medications must be stored in a locked cabinet in the health room.

OTC Treatment Permission: Please mark (x) by each OTC you approve of for use for your child.

Topical:
____ Antibiotic cream for minor cuts/scrapes
____Hydrocortisone Cream for itching/eczema/dermatitis
____Calamine for minor rashes/bug bites/poison ivy
____Sunscreen
____Lotion or Vitamin E for dry skin
____Eye drops for dryness
____Other: _____

Oral:
____Acetaminophen* (Tylenol) for minor headaches/aches/pain
____Ibuprofen* (Advil, Motrin) for minor headaches/aches/pain
____Antacids (Tums or equivalent) for indigestion
____Antihistamine for allergy symptoms or allergic reaction
____Cough drops / Throat lozenges
____Cough syrup
____Other: _____

*Acetaminophen and Ibuprofen will not be given together without a physician's order. Please choose and send one or the other.

Child has taken the above medication(s) previously without an adverse reaction: Yes ☐ No ☐

I relieve Haysville USD 261 of any responsibility for the consequences of administering the requested OTC medication and acknowledge that the school incurs no liability for damage, injury, or death resulting directly or indirectly from the administration of the requested OTC medication.

_____ _____
Parent/Guardian Signature Date

Parent/Guardian Name: _____

Phone: _____

Comments/Special Instructions from parent: _____

_____

_____