

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



**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 label instructions indicate a daily dose.** 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: _____

