



**Permission to Administer
Non-Prescription Medications**

Name of student _____ School Year _____
Date of birth _____

Parent/Guardian _____
Telephone # _____ Cell _____

Please list any medications your child is currently taking

Please list any allergies your child has to medications

Please list any medical problems your child has _____

CONSENT

I grant permission to the school nurse or the trained designated agent to administer the following non-prescription medications as needed. My child has received these medications at home and has no adverse reaction to them. (Please check only those medications that apply.)

- | | |
|--|---|
| <input type="checkbox"/> acetaminophen (Tylenon) | <input type="checkbox"/> ibuprofen (Advil)* |
| <input type="checkbox"/> antacid (e.g. Tums, Rolaids)* | <input type="checkbox"/> cough drops |
| <input type="checkbox"/> calamine lotions (Caladryl) | <input type="checkbox"/> antibiotic treatment |
| <input type="checkbox"/> Solarcaine.aloe | <input type="checkbox"/> Bactine |
| <input type="checkbox"/> Orajel | <input type="checkbox"/> Vaseline/Blistex |
| <input type="checkbox"/> sunscreen | |

* for children ages 12 and over

Signature of parent/Guardian _____ Date _____