



**SAINT
IGNATIUS**

Cleveland · Jesuit · 1886

Over-the-Counter Medication Permission Form

The school nurse does not keep over-the-counter medications in stock. If your son needs to take over-the-counter medications, you must complete this form and turn this form along with the medication in the original bottle into the school nurse. Attach this form to the completed **Authorized to Self-Administer Medication Waiver Release form**. Please check with your doctor/pharmacist that the medications below do not interact with any medications your son may already be taking.

Student's Last Name _____ First Name _____ DOB _____ Grade ____

_____, My son may see the school nurse or designated school employee and self-administer the over-the-counter medications I/we have provided as indicated below if deemed appropriate based on his presentation/symptoms. I understand that these medications must be in the original container and may only be used according to the package directions. I/we have checked with his physician/pharmacist to verify the safety with his other medication(s).

- ___ Acetaminophen (Tylenol) 325mg tablets (1 or 2)
- ___ Ibuprofen (Motrin/Advil) 200mg tablets (1 or 2)
- ___ Saline eye rinse &/or nasal spray
- ___ Benadryl antihistamine (for generalized allergic reaction) 25mg
- ___ Benadryl or cortisone cream (topical itching/rash)
- ___ Tums antacid
- ___ Cough Drops (menthol, i.e. Halls)

___ I/we have provided over-the-counter medications not listed above that my son may self-administer when necessary. This medication is to be stored with the school nurse. I understand that these medications must be in the original container and may only be used according to the package directions. I/we have checked with his physician/pharmacist to verify the safety with his other medication(s). These OTC medications are listed below:

This signed form must accompany all OTC medications provided to the school nurse or designated school employee by the parent/guardian.

I/we consent to allow my son to self-administer OTC medications identified above and made available to him by school staff and have completed the necessary self-administration waiver and release.

Parent/Guardian Signature _____ Date _____

Printed Name: _____ Phone: _____