ST BARTHOLOMEW CATHOLIC SCHOOL PERMISSION FOR NON-PRESCRIPTION MEDICATION

Student Name____

Grade ________**Date of Birth:** _________________**Age:** ________________________________

My Son/Daughter may receive the medication(s) I have checked below. I understand that if my child routinely needs medication that I will supply the medication.

All medications will be dosed per weight or age. Please check the following if you give permission for your child to have these medications or ointments if sick or injured during the school day.

YES___ NO____ Tylenol (Acetaminophen) every 4 to 6 hours as needed for pain or fever.

YES___ NO___ Advil (Ibuprofen) every 4 to 6 hours as needed for pain or fever.

YES___ NO___ Benadryl (Diphenhydramine) as needed for stings insect bites and allergic reactions.

YES___ NO___ Cough Drops as needed for cough.

YES___ NO___ Saline Eye Drops as needed to remove debris from eyes.

YES___ NO___ Tums, 1 or 2 tablets, or Pepto Bismol, 1 or 2 tablets as needed for an upset stomach.

YES___ NO___Topical Preparations for skin wounds and insect bites such as: Hydrogen Peroxide, Bacitracin, Neosporin, Vaseline, and Hydrocortisone Cream, to use as needed.

I authorize the nurse or school personnel, under the supervision of the school nurse, to be my agent, to give medication checked above to my child. Please note, generic brands may be substituted and all medications will be given sparingly.

Additional comments/instructions:

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Allergies: ____

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Signature of parent/Guardian: ______________________________________**Date**_______________