OVER THE COUNTER MEDICATIONS

_____ _____ **2014-2015 School Year**

Student Name **Grade**

Dear Parent/Guardian,

I have standing orders from our school physician, Dr. Costellanos, for over-the-counter medications listed below. The school doctor has prescribed any and all restrictions to the conditions as to when these medications can be given.

With your permission, and **YOUR DOCTOR'S** signature we can give these medications to your child whenever he/she comes to the health office. School nurses are prohibited from giving any medications without **doctor's orders** and parental consent. No child will receive more than two tablets of a pain reliever, and only once during the day.

Please indicate yes or no for your permission for **EACH** medication. These will be used together with the doctor's orders and recorded when given. Please sign and date the bottom of this form, *as well as* your child's physician, and return it to me listing any known allergies.

__ Yes __ No Benadryl for allergies

__ Yes __ No Tylenol for headaches/pain

__ Yes __ No Ibuprofen for muscle pain, cramps

__ Yes __ No Antacid for upset stomach

__ Yes __ No Neosporin ointment for minor wound care

__ Yes __ No Aloe lotion for minor burns

__ Yes __ No Caladryl lotion for bug bites/irritated skin

__ Yes __ No Artificial tears for red/tired eyes

__ Yes __ No Tylenol Cold and Sinus

Known allergies_____

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Physician's Signature **Date**

If you have any questions, please call me at (607) 836-3606, Dulcie Turner, RN