Over-the-Counter Parental Permission

Dear Parent/Guardian,

To treat your child for minor discomfort and keep them as comfortable as possible during school hours, without disruption to their education, please check the boxes below, sign and return to school asap. ***IF you have already checked the Over-the-Counter box on the Health History form, you do NOT have to fill this form out.***

Students Name Grade

Please CHECK below:

- ☐ **YES**, I, **Parent/Guardian** of student listed below, ***give* permission** for my child to have OTC medications listed below.
- ☐ My child has No Known DRUG Allergies (example: aspirin)
- ☐ My child has No Known FOOD Allergies (example: red dye, eggs)

- ☐ Tylenol (Acetaminophen) &
- ☐ Advil/Motrin (Ibuprofen) - muscle aches, headaches, menstrual cramps, or other minor discomforts
- ☐ Tums – upset stomach, indigestion
- ☐ Cough Drops – cough
- ☐ Benadryl – allergic reactions (only)

- ☐ **NO**, I, Parent/Guardian of child listed below, do ***not*** give permission for my child to have the medications listed on this sheet, during school hours.
- ☐ MY child IS ALLERGIC TO the following ingredients in the above medications:____________________
- ☐ **Specific Instructions** from parent/guardian, if any____________________

I give my permission to the school nurse or designated personnel to administer the above medication(s) in school and/or on class trips, to the student indicated on this form, for this school year only. I acknowledge the school nurse, designated personnel and school shall incur no liabiltiy because of any condition arising from administering the above medication(s). I indemnify and hold harmless the school and its employees or agents against claims arising from the administration of the above medication(s).

Healthy Regards,
Michele Avallone (ES), RN, BSN, CSN
Julie Kosylo (ES), RN, BSN, CSN
Sherry L. Richards (MS & HS), RN, BSN, CSN

Parent/Guardian ***{Signature}*** Date

**This form is good for ONE school year! Updated 6/5/17*