Indian Hill Board Office

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http://www.indianhillschools.org
NATIONALLY RECOGNIZED FOR EXCELLENCE IN EDUCATION

Indian Hill Exempted Village School District

Over the Counter Medication Permission Form

Name of Student _____ **Grade** _____

Medication Allergies: Yes/No If yes, please list: _____

I give permission for my child to receive the following medication at school as indicated:

___ Acetaminophen 650 mg every 4-6 hours as needed

___ Acetaminophen Jr dose per package instructions every 4-6 hours as needed

___ Ibuprofen 400 mg every 6-8 hours as needed

___ Ibuprofen Jr dose per package instructions every 8 hours as needed

Acetaminophen and Ibuprofen may be given as the discretion of the school nurse for temporary relief of minor aches and pains associated with the common cold, headache, muscular ache, orthodontic aches. Note: If dose is not indicated below for Over the Counter Medications, package directions will be followed.

___ Triple Antibiotic topically, as needed, for minor wounds

___ Hydrocortisone 1% cream topically, as needed, for minor itching

___ Caladryl clear lotion topically, as needed, for minor itching due to bug bites

___ Diphenhydramine 12.5 mg-50 mg PO every 4-6 hours as needed for minor allergic reactions

___ Cough drops, one drop every 2 hours, as needed, for mild sore throat or cough

___ Saline flush for minor eye irritation

___ Calcium Carbonate: indigestion, upset stomach that is minor in nature

___ Sting kill swabs: topical anesthetic for insect stings

___ Vaseline: chapped skin and lips sites of friction without erosion

The above listed medications are the only medications routinely stocked by the school nurse for student use. Other over the counter medications may be administered by the school nurse when supplied by the parent and accompanied by a written request from the parent AND Health Care Provider.

I give permission for my child to use the over-the-counter medications as indicated above. **This permit will no longer be valid at the end of the current school year.** I will immediately notify the school nurse in writing should my child develop any condition. or begin taking medication which would preclude the safe administration of any of the above medications, or need to terminate the use of this medication for any reason.

Parent/guardian signature: _____ Date: _____