School Year 2019-2020

New forms must be completed every year

School District of South Milwaukee
Parent permission to give Occasional Over the Counter Medications

Student Name_____ School _____ Grade _____

Over-the-counter (OTC) medications are drugs that do not require a prescription and are purchased "over-the-counter". This form is required before OTC medications can be administered at school. Exceptions to this are homeopathic/herbal medications and aspirin. Dosing will be done by the label recommendation by weight.

The school is not able to supply medication for frequent or daily use. If using greater than 2 times in a month, you will be required to provide the medication for your child.

Please initial each medication for which you are giving permission

_____ I approve **ALL** medications listed below**.**
_____ I do **NOT** want my student to be given OTC medications.
_____ I approve **ONLY** the medications I have initialed.

Topical:	Oral:
___ Antibiotic cream (i.e. Bacitracin, Polysporin)	___Ibuprofen (i.e. Motrin, Advil)
___Hydricortisone Cream1%	___Acetaminophen (i.e. Tylenol)
___Diphenhydramine cream (i.e. Benadryl, Caladryl)	___Calcium carbonate antacid (i.e. Tums, Maalox)
___Oral benzocaine cream/spray (chloraseptic)	___Cough Drops
___Burn Spray	___ Antihistamine (i.e. Benadryl)
___Sting wipes	

____I would like to be notified by phone if my student receives OTC medication.

The medications indicated above may be administered to my student.

_____ _____
(Signature of Parent or Guardian) **(Date)**

When sending OTC medications to school they must be in the original manufacturer's container with the label intact or the medication will not be accepted.

Medication History

Is your student allergic to any medications? ____ If yes, please list the medication(s) and type of reaction:
_____

Does your student take any medication on a regular basis (prescription or OTC)?____ If yes, please list:_____

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Office Use Only

Date/Time	Medication/Dose/Initial	Date/Time	Medication/Dose/Initial