IMMACULATE CONCEPTION SCHOOL of LOWELL

Over the Counter (OTC) Medication Authorization Form

Occasionally a student will develop symptoms during school hours such as fever, headache, muscle pain, menstrual cramps, allergies, or other minor cold symptoms. The student's symptoms may be helped by over the counter medications such as those available in the Health Office and listed below. Prior to any administration of these over the counter (OTC) medications the Health office staff assesses whether the student may benefit. However, written parental consent is needed before ANY medication(s) can be given. Please complete the form bellows part of your child's health record. This form needs to be signed and returned whether or not you allow the Health Office staff to administer any over the counter (OTC) medications to your child. One form is needed for each child with the original SIGNED copy to be kept on file at ICS. This permission form is valid only for the 2016-2017 year and a new form will need to be filled out for each new school year.

Student Name: _____ Grade: _____

Age:_____ Weight in Pounds:_____ Allergies to food or medicine: ☐ NO ☐YES

Please List Allergies:_____

☐**I give permission for the Health office staff to administer the following over the counter (OTC) medication(s) to my child after assessment WITHOUT contacting me at the time of administration.**

Please check all medications that apply.

If a medication in not listed below, please supply the OTC medication in its original container and sealed!

Junior Strength Tylenol	__YES	__ NO
Junior Strength Motrin	__YES	__NO
Cough Drops (ex. Halls, Lunden's)	__YES	__ NO
Ora-Gel	__YES	__ NO
Tums/Antacid	__YES	__ NO
Other_____	__YES	__NO

***Students depending on age and weight may get the regular strength Tylenol or Motrin*

Parent/Legal Guardian Signature: _____ Date: ____/_____/_____

☐**Please contact me prior to ANY OTC medication(s) administration.** ***(Please note if box is checked your child will NOT receive any medication until you are reached)***

Parent/ Legal Guardian Signature_____ Cell#_____ Date____/____/____

PLEASE NOTE ** A doctor's order is needed for any prescription medication that is needed to be administered at school, or if any OTC medication is needed to be given 3 or more consecutive days. Please call/ see nurse for any questions.