PRINCE of PEACE CATHOLIC SCHOOL

2018-2019 AUTHORIZATION TO ADMINISTER OTC MEDICATION

Student's Name: _____ Age: _____ Current Weight: (for dosing purposes) _____

The school nurse will carry the following medications to be dispensed at her discretion. If you would like your child to be treated, please indicate so by filling in the spaces below. Remember, a medication sheet ***must*** be filled out for each child and signed by a parent ***before*** any medication can be administered. ***All medication must be dispensed by the nurse and dosing will be per medication container instructions.***

I give permission for my child, _____, to be treated with the
Child's Name
following medication(s) when deemed necessary by the POP nurse.

Please check *all* that apply and indicate appropriate dosage where necessary.

____ **TYLENOL** (acetaminophen) – for headache/cramps/orthodontic pain, or fever above 100°
_____ Junior Strength 160 mg
_____ Regular Strength 325 mg

____ **ADVIL** (ibuprofen) – in lieu of Tylenol
_____ Junior Strength 100 mg
_____ Regular Strength 200 mg

____ **CORTISONE** (hydrocortisone) – for itching associated with minor skin irritations, rashes, or bug bites
_____ 1% cream/spray

____ **ANTIBIOTIC CREAM** – for minor cuts, scrapes, or burns

____ **TUMS** (calcium carbonate) – for occasional stomach aches or indigestion

____ **GAS X** (simethicone) – for occasional discomfort from gas pains

____ **MOISTURIZING EYE DROPS** – for dry/irritated eye relief

____**BENADRYL** (diphenhydramine HCl 12.5 mg)- for minor allergic reactions/bee stings

_____	_____	_____
Parent's Name Printed	Parent's Signature	Today's Date

_____	_____	_____
Cell Number	Home Number	Work Number