Sacred Heart School

63 Sacred Heart Lane, PO Box 3672, Glyndon, MD 21071-3672 P 410-833-0857 F 410-833-0914

"Over-the-Counter" (Non-Prescription) Medication Form

(To be completed by Physician AND Parent/Guardian.)

Student's Name: _____ **Grade**: _____

DOB: _____ / _____ / _____

Allergies: _____

List medications your child receives regularly: _____

The Health Suite personnel will not administer any medication if your child has never received it in the past. Please check any medications you wish to be made available to your child under nursing discretion: Dose is dependent on child's age/weight.

For headache /fever/ muscle aches/ earache/ orthodontic discomfort/ pain:

(____) ACETAMINOPHEN (i.e. Tylenol)
(____) IBUPROFEN (i.e. Advil, Motrin)

For mild allergic reactions:

(____) DIPHENHYDRAMINE (i.e. Benadryl)

For mild skin irritation (itchy rashes, poison ivy/oak, insect bites):

(____) TOPICAL ANTI-ITCH GEL/CREAM (i.e. Blue Star Ointment, contains camphor)

For mild stomach discomfort:

(____) ANTACID (i.e. TUMS or generic equivalent)

For sore throat/cough without fever:

(____) COUGH DROP (generic brand, contains Menthol)

I give permission for my child _____ to receive any medication I have indicated above as deemed necessary by the School Nurse / designee. I understand that generic equivalent medication may be used.

(____) Dispense medication only with prior (same day) phone notification.

_____	_____	_____
Physician's Signature	Office phone number	Physician's Name (Printed)
_____	_____	_____
Parent/Guardian Signature	Phone number	Parent/Guardian Name (Printed)

No medication will be given without proper documentation.
Physician's signature is **required** on this form.

Updated 5/2014