

Permission for Over-the-Counter Medication at School

Unified School District 490
El Dorado Public Schools, El Dorado, KS

I, the undersigned Parent or Guardian, hereby request for the following over-the-counter medications to be administered to my child as the school nurse or other school personnel trained by the nurse deems appropriate. I understand that USD 490 and any school employee who administers medication to my child in accordance with the following request shall not be liable for damages.

Student's Name	Date Of Birth	Grade	School
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ALLERGIES: _____

Please put your initials by the medications listed below that you have provided and request our nursing staff or designee to administer to your child.

- _____ **1. TYLENOL/GENERIC:** May be given per product instructions for either headache or minor pain. The dose may be repeated every 4 – 6 hours as needed.
- _____ **2. IBUPROFEN-MOTRIN/GENERIC:** May be given per product instructions for either headache or minor pain. The dose may be repeated every 4 – 6 hours as needed.
- _____ **3. GENERIC ANTIHISTAMINES/ALLERGY MEDS:** May be given per product instructions for relief of sneezing; itchy, watery eyes; runny nose and itchy throat due to allergies.
- _____ **4. HYDROCORTISONE CREAM 0.5% CALAMINE LOTION or CALADRYL:** May be used topically per product instructions for relief of itching due to insect bites or poison ivy.
- _____ **5. THROAT SPRAY OR LOZENGES:** May be given per product instructions for relief of a sore throat.
- _____ **6. TUMS/GENERIC** May be given per product instructions for relief of mild nausea or stomachache.
- _____ **7. NEOSPORIN/TRIPLE ANTIBIOTIC GENERIC OINTMENT:** May be used on mild cuts, scrapes and abrasions.

I understand that I will be notified anytime any if the above approved medications are administered and that medical follow-up may be recommended if my child has persistent, recurring physical complaints.

Signature of Parent or Guardian	Date
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This request will expire at the end of the current school year.