Saint Charles Catholic School

OVER THE COUNTER MEDICATION AUTHORIZATION FORM

Dear Parent or Guardian:

Occasionally during the school day a pupil becomes ill, (i.e. headache, toothache, menstrual cramps, sore throat, upset stomach, etc.) His/her discomfort may be relieved with an over the counter medication such as ibuprofen, antacid, etc. These medications would be available through the school clinic, and to the student based on the assessment by the school nurse or authorized office personnel, but **ONLY WITH PARENT PERMISSION.**

Your decision will remain in effect for the current school year unless you notify the clinic of any changes. We recommend you consult your family physician regarding the effects of the following medications before signing the paper.

Thank you.

Please mark an x for each medication and dosage (if applicable) you approve:

_____ Ibuprofen (i.e. advil)
Dosage: _____ 200 mg _____ 400 mg

_____ Acetaminophen (i.e. Tylenol)
Dosage: _____ 325 mg _____500 mg _____ 650 mg

_____ Calcium Carbonate (i.e. Tums)
_____ Pepto Bismol
Dosage: _____ 1 tablet _____ 2 tablets

_____ Allergy Pills
Type: _____ Zyrtec _____ Claritin

Comments or concerns: _____

_____

If it appears a pupil is forming a pattern of repeated and/or frequent requests for any of the above medications, the parents/guardians will be informed.

_____ _____
Name of Pupil Signature of Parent/Guardian

_____ _____
Grade/Homeroom Date