

WORCESTER PUBLIC SCHOOLS
DEPARTMENT OF NURSING
Parent Consent to Administer Over the Counter Medication
2015– 2016

Student Name: _____ **Grade:** _____

MEDICATIONS PROVIDED DURING SCHOOL HOURS:

- Acetaminophen (Tylenol)
- Ibuprofen (Motrin)
- Bacitracin Ointment
- Calamine Lotion
- Diphenhydramine (Benadryl)
- Tums **(middle and high school students only)**

IMPORTANT INFORMATION FOR PARENT/GUARDIAN:

Your written consent is required before your child is able to receive these medications at school. Please complete the entire form. By signing below, you acknowledge the following:

- You have received this information and agree that your child may safely take the recommended dose.
- The school nurse has the responsibility of approving your child's use of these medications. In the case of a child with special health care needs, the school nurse may request authorization from his/her physician.
- A physician's (or other licensed prescriber's) authorization will be required if:
 - Your child requires more than 3 doses of acetaminophen, diphenhydramine, and/or ibuprofen in a 30 day period;
 - Your child requires more than 3 consecutive daily doses of Acetaminophen, diphenhydramine, and/or ibuprofen;
 - In the judgment of the school nurse your child is ill and not improving.
- **ONLY** the school nurse will administer/apply these medications.
- In the event your child is ill and school policies require exclusion/dismissal from school, your child will still be excluded/dismissed, regardless of the use of medication.
- This service is intended to help your child's performance during the school day. The nurse will not administer medication within 30 minutes of dismissal except at his/her discretion.

I give permission to the school nurse to administer/apply the following medications to my child _____ according to approved guidelines (check if you approve):

(Child's Name)

Acetaminophen (Tylenol) _____

Ibuprofen (Motrin) _____

Bacitracin Ointment _____

Calamine lotion _____

Diphenhydramine (Benadryl) _____

Tums _____ **(middle and high school only)**

Please complete the following:

My child has taken acetaminophen (Tylenol) before without a problem: Yes ___ No ___

My child has taken Ibuprofen (Motrin) before without a problem: Yes ___ No ___

My child has used Bacitracin before without a problem: Yes ___ No ___

My child has used Calamine lotion before without a problem: Yes ___ No ___

My child has used Diphenhydramine (Benadryl) before without a problem: Yes ___ No ___

My child has used Tums before without a problem: Yes ___ No ___

Please call me before my child receives any medication: Yes ___ No ___

Please send home a note after my child receives any medication: Yes ___ No ___

Contact Name and Phone Number _____

My child is taking other medications at this time: Yes ___ No ___ (please list) _____

Special instructions concerning my child: _____

To the best of my knowledge, my child has no allergy/sensitivity to any of the above named products.

Parent/Guardian Signature: _____ **Date:** _____