School Year_____
New form must be filled out every year.

Lisbon Regional School

PARENT PERMISSION TO GIVE "OCCASIONAL" OVER-THE-COUNTER MEDICATION
Grade 5-12 ONLY

Student Name: _____Grade: _____Date: _____

Over-the-Counter (OTC) medication are drugs that do not require a prescription and are purchased "over-the-counter." This form is required before over-the-counter medication can be administered at school.

PLEASE INITIAL EACH MEDICATION FOR WHICH YOU ARE GIVING PERMISSION

_____ I approve all medications listed below

_____ I do not want any OTC meds given to my student

TOPICAL:

_____ Antibiotic cream (i.e. Neosporin)

_____ Hydrocortisone cream (i.e. Cortaid)

_____ Benadryl cream (i.e. Caladryl, Diphenhydramine)

_____ Burn gels

ORAL:

_____ Ibuprofen (i.e. Advil, Motrin)

_____ Acetaminophen (i.e. Tylenol)

_____ Benadryl (emergency only)

_____Tums

OTC medication will be given at the manufacturer's recommended dosage.

The MEDICATIONS INDICATED ABOVE MAY BE ADMINISTERED TO MY CHILD

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

The school is not able supply medication for frequent or daily use. If the medication must be given on a regular basis, please use the form "Prescription Medication Administration Form".

MEDICATION HISTORY:

Is your child allergic to any OTC medication? _____

If yes, please list medicine(s) and type of reaction: _____