



Over The Counter Medications Permission Form

Dear Parent/Guardian:

In the event that your child complains of a minor illness, (i.e. headache, stomach ache, cough or cold symptoms, sore throat, menstrual cramps or minor aches and pains) during the school day, there is a list of “**over the counter medications**” that may be administered to your child by the School Nurse.

Please check all the medications that you would like your child to receive in the event of a minor illness. **Please complete this form and email directly to creid@ridgenet.org.**

- | | |
|-------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Advil (headaches, aches and pains) | <input type="checkbox"/> Pepto-Bismol (diarrhea-stomach aches) |
| <input type="checkbox"/> Anbesol/Orajel (tooth aches) | <input type="checkbox"/> Rolaids/Tums (stomach aches) |
| <input type="checkbox"/> Eye Drops Hydrocortisone Cream 1% | <input type="checkbox"/> Tylenol (headaches, aches and pains) |
| <input type="checkbox"/> Lozenges (sore throat) | <input type="checkbox"/> Zyrtec/Benadryl (allergies) |

Child’s name _____

Home Telephone number _____

Allergies: _____

Medical Problems: _____

Medications Taken Currently: _____

Other information regarding your child that you would like the School Nurse-teacher to know:

YES, administer “**over the counter medications**” to my child if needed during the school day.

NO, do not administer any “**over the counter medications**” to my child during the school day.

Parent/Guardian Signature

Date