La Salle High School

OVER-THE-COUNTER MEDICATION FORM

(Name of student)_______________________________________(Year)_____________

Medication allergies: Yes/No   If yes, please list:_________________________________

I hereby request and give my permission to the principal or his delegate (nurse or other responsible person) to administer the following mediation at school to my child as indicated:

_____ Tylenol (650 mg every 4-6 hours as needed)

_____ Ibuprofen (400 mg every 4-6 hours as needed)

_____ Alleve (220 mg every 12 hours as needed)

Tylenol, Ibuprofen, or Alleve may be given at the discretion of the nurse at school for temporary relief of minor aches and pains associated with the common cold, headache, toothache, muscular aches, or pain associated with an injury.

_____ Opcon-A eye drops: 1-2 drops per eye may be given once daily for temporary relief of inching and redness caused by seasonal allergies.

_____ Antacid tablets (Tums): 2 chewable tablets may be given at the discretion of the nurse for complaints of heartburn or acid indigestion.

_____ Antibiotic ointment, Ivarest anti-itch gel, and 1% hydrocortisone cream: may be used as needed for first aid.

The above listed medications are the only medications routinely stocked by the nurse at school for student use. Other over-the-counter medications may be administered by the nurse when supplied by the parent and accompanied by a completed Parent's Request for the Administration of Medication Form.

I request and give permission for my son to use the over-the-counter medications as indicated above. This permit ends with the current school year. I will immediately notify the nurse in writing should my son develop any condition, or begin taking medication which would affect his ability to take any of the above mediations safely, or need to terminate the use of this medication for any reason.

Signature of parent/guardian: ____

Date: ______________