**EARLY CHILDHOOD PROGRAM**
**AUTHORIZATION FOR NON-PRESCRIPTION OVER-THE-COUNTER MEDICATIONS**

**THIS FORM NEEDS TO BE COMPLETED AND SIGNED BY THE PARENT AND PHYSICIAN**

*Ideally medications should be given at home. The school recognizes that minor symptoms can occur that require the use of non-prescription medications for treatment. At times it is difficult to reach parents to get permission to administer this medication. The school office/school nurse has over-the-counter medications in stock, which can be administered if requested by the parent on this form. Please discuss your wishes regarding over-the-counter medication with your pediatrician.*

*Many over-the-counter medication instructions recommend consulting with a pediatrician if the child is under a certain age. Before granting permission to the school to give over-the-counter medications, please check with your physician to make sure that these medications are recommended, will not react with any other medication(s) the student is already taking, and the appropriate dosage is provided.*

| Student's Last Name | Student's First Name | MI | Sex | Date of Birth | Grade |
|---|---|---|---|---|---|
| _____ | _____ | ____ | ____ | _____ | ____ |

_____ No, my child may not have over-the-counter medications

_____ Yes, the school nurse/teacher may administer over-the-counter medications that I have indicated below. I have checked with my child's physician to verify recommendations, dosing, and safety with other medications.

Please list student allergies _____

Please list other medications the student is currently taking _____

Please check below any medications that the school may supply to your child.

**First Aid Medications:**
___ Neosporin antibacterial ointment (infection prevention on cuts/scrapes)
___ Neosporin Antiseptic wash (wound cleaning)
___ Purified water or saline eye rinse

**For Allergy Symptoms:**
___ Benadryl antihistamine (generalized allergic reactions) Dosage ____
___ Benadryl/Cortisone anti-itch topical cream (skin reactions)
___ Claritin antihistamine (non-drowsy for seasonal allergy symptoms) Dosage_____

**For Pain Relief:**
___ Ibuprofen (Motrin/Advil) Dosage_____
___ Acetaminophen (Tylenol) Dosage_____

Parent/Guardian's Signature(s) _____ Date _____

Physician's Signature _____Date _____