



Dear Parent/Guardian:

We are aware that you may not be accessible by phone some days. We have approval from the State Board of Nursing to administer a minimal number of over-the-counter medications to students. Please place a check mark in front of the one(s) you give the school nurse permission to administer according to the package directions for age or weight.

- | | |
|-------------------------------------|---|
| _____ ibuprofen (Advil) | for migraine or other headache, |
| _____ acetaminophen (Tylenol) | menstrual cramps, musculoskeletal pain, |
| _____ antacid (Tums) | dental pain, earache or sore throat. |
| _____ cough drops | for stomach ache |
| _____ lubricant eye drops (ReFresh) | for sore throat |
| | for eye irritation |

Our budget allows for only 2 doses of each medication. You will need to supply any additional doses. The medication must be in the original container and labeled with your child's first and last name. Due to minimal storage space, please supply the medication in a small bottle (50 tablets or less).

Please read, date, and sign the following statement:

I hereby give my permission for *(student name)* _____ *(grade)* _____ to take the medication(s) as indicated above. I further understand that the nurse or her designated assistant shall not be liable for damages that might occur from an adverse reaction suffered by the student as a result of administering the drug.

Signature of Parent/Guardian

Date

- Please check this box if you would prefer we attempt to contact you before giving the medication listed above.