



# St. Catherine School

School Year: \_\_\_\_\_

New forms must be completed every year

## PARENT PERMISSION TO GIVE “OCCASIONAL” OVER-THE-COUNTER MEDICATION

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Over-the counter (OTC) medications are drugs that do not require a prescription and are purchased “over-the-counter”. This form is required before over-the-counter medications 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(s)

#### **TOPICAL:**

\_\_\_\_\_ Antibiotic Cream (i.e. Neosporin)

\_\_\_\_\_ Hydrocortisone Cream (i.e. Cortaid)

\_\_\_\_\_ Benadryl Cream

\_\_\_\_\_ Bee Sting Gel

#### **ORAL:**

\_\_\_\_\_ Ibuprofen (i.e. Advil, Motrin)

\_\_\_\_\_ Acetaminophen (i.e. Tylenol)

\_\_\_\_\_ Antihistamine (i.e. Benadryl)

OTC medications will be given at the manufacturer’s recommended dosage.

**THE MEDICATIONS INDICATED ABOVE MAY BE ADMINISTERED TO MY STUDENT(S)**

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)

### **THE SCHOOL IS NOT ABLE TO SUPPLY MEDICATION FOR FREQUENT OR DAILY USE**

Does your student have any allergies? \_\_\_\_\_ Please list: \_\_\_\_\_

Does your child take any meds on a regular basis? \_\_\_\_\_ Please list: \_\_\_\_\_

When sending OTC medications to school, they must be in the original manufacturer’s container with the label intact or the meds will not be accepted. For safety reasons, parents are requested to bring the meds directly to the office. In the event that an adult is unable to bring the meds to school, arrangements may be made by calling the school office.