Over-The -Counter Medication Authorization Form

Dear Parent or Guardian:

We have over-the-counter medications available to students in the health suite if needed on an occasional basis. These medications are intended to alleviate minor discomforts and prevent missed time from classes and unnecessary early dismissals from school. These medications will only be given if the child's physician and parent have signed the ***Over-The-Counter Medication Authorization Form*** which is on the reverse side of this letter.

The ***Over-The -Counter Medication Authorization Form*** must be completed and signed by both the parent and the child's physician to give consent for the administration of the listed medications which are available at no charge for all students. The school nurse will administer these medications based on the original package directions unless otherwise specified by the physician.

This form must be filled out each school year.

These medications are intended for occasional use only. **If your student requires any prescription or nonprescription medication to be given on a regular basis in school , you must obtain a written order by having your child's physician complete a *School Medication Administration Authorization Form* (available on the school website) and supply the medication to be kept in school.**

If you have any questions or would like further information, please contact Ellen Marquardt at 410-825-2323 EXT 244 or ellenmarquardt@concordiaprepschool.org.

Sincerely,

Ellen Marquardt, BSN, RN

CONCORDIA PREPARATORY SCHOOL

Over-the-counter Medication Authorization Form

School Year: _____ Grade:_____

Student Name: _____ Date of Birth ___/___/___

Allergies: _____

Current Medications: _____

_____ **I DO NOT WANT ANY OVER-THE-COUNTER MEDICATIONS GIVEN TO MY CHILD AT SCHOOL.** _____ **Date:** _____

Parent/Guardian Signature

Over-The-Counter Medication Authorization

Type of Medication* * The generic equivalent may be used in place of brand name.	**Description of symptoms for which medication** should be administered.** ** All medication will be administered according to original package instructions.	**This student is authorized to be administered this Medication.** (Please Circle)	
Acetaminophen (i.e. Tylenol)	Headache, muscle aches, pain, menstrual cramps, fever	Yes	No
Ibuprofen (i.e. Motrin, Advil)	Headache, muscle aches, pain, menstrual cramps, fever	Yes	No
Cough drops / Sore throat lozenges	Coughs and minor sore throat pain	Yes	No
Calamine Lotion	Minor skin irritation	Yes	No
Antibiotic Ointment	Cuts, scrapes and /or abrasions	Yes	No
Hydrocortisone 1%	Rash, inflammation, insect bites, itch	Yes	No

Physician's Comments: _____

_____

Physician Signature:_____ Date: _____

Physician Printed Name: _____ Phone Number:_____

Note: NO Over-the-counter medication will be given without a physician's signature.

I hereby authorize the above named student to receive any (OTC) medication indicated above from the School Nurse. I understand the generic equivalent of medications may be used. I understand that the medication will be administered as directed on the original manufacturer container unless otherwise noted by the physician. A physician's signature as well as a parent's (or legal guardian) signature are required for these medications to be given.

_____

Parent/Guardian Signature **Date:**