

OVER the COUNTER MEDICATION CONSENT – signed by Doctor & Parent

Dear Parents:

The policy for over the counter (OTC) medication administration is according to the standards that are mandated by the Howard County Health Department and the Nurse Practice Act of Maryland. **Over the counter medications will not be dispensed without the written consent of the parent and the student's physician.** There will be no exceptions. Below is an Over the Counter (OTC) form that gives permission from both you and your child's doctor to administer OTC medicines that will be available to the students for occasional symptoms. You will be notified if your child receives an OTC medicine in the health room.

The policy for Prescription medications remains the same. **Prescription medications that need to be given to the student during the school day must be accompanied by a signed Medication Order Form from the prescribing physician** and be in the original container (your pharmacist will give you a second labeled container for school use if you request it).

We appreciate your cooperation and ask that you call if you have any questions regarding any aspect of these policies. Looking forward to a happy and healthy year for all.

Trinity School Nurses 410-744-1082

CONSENT for ADMINISTRATION of OVER the COUNTER MEDICATIONS-School Year – 11/12

Student's Name: _____ **AGE** ____ **GRADE** _____

Allergies _____

List any long-term medications now receiving _____

CHECK MEDICATION IF OK TO GIVE IN SCHOOL – ONLY medications listed below will be available to your child in School. Any other medication will need a separate Medication Order Form. **Please indicate dosage if applicable.**

_____ Medicated Cough drops _____ Anti-itch gel (CalaGel) _____ Benadryl gel for minor rash

_____ Medicaïne Swab Sting & bite relief _____ **3 in 1** Antibiotic Ointment _____ Saline eye drops

_____ Motrin (Ibuprofen) - **Rx** _____

_____ Tylenol (Acetaminophen) - **Rx** _____

_____ Benadryl (liquid or tablet) - **Rx** _____

_____ I **DO NOT** want any medication given to my child in school

****Parent/Guardian Signature** _____ **Date** _____

***Physician's Name** _____ **Phone #** _____
(please print)

***REQUIRED:**
Physician's Signature _____ **Date** _____