HENDERSON COUNTY PUBLIC SCHOOLS
AUTHORIZATION FOR ADMINISTRATION OF OVER-THE-COUNTER (OTC) MEDICATION

I. **Student information**

_____ _____ _____ _____ _____
Last Name, First Name, Middle Initial | Date of Birth | Weight* | School | Grade/Teacher

_____ _____
Parent/Guardian Name | Cell Phone/Work Phone

1.) Does your student have any allergies to medications, food/drink, or dyes? _____ (Yes/No)
2.) If yes, please list allergies and type of reaction (for example: Penicillin-rash).
_____
3.) Does your student take medication (either over-the-counter or prescription) on a regular basis? _____(Yes/No)
4.) If yes, please list medication (including name, dose, and frequency; for example: Claritin 10 mg daily)
_____
5.) Does your student have a diagnosed medical condition that impacts their safety when taking over-the counter medication (including, but not limited to: history of kidney or liver disease, hypertension, or pregnancy)? *If uncertain, please contact your student's primary care physician*
_____(Yes/No). If yes, please describe: _____

II. Action Plan; Effective school year _____; Check "yes" or "no" to indicate which medicine(s) may be administered to your student.

Medication	**Indication(s)**	**Possible Side Effects**
Acetaminophen (Tylenol) ☐ Yes ☐ No	For fever of 100 F or greater or relief of minor aches & pains..	Nausea, rash, headache
Ibuprofen (Advil/Motrin) ☐ Yes ☐ No	For fever of 100 F or greater or relief of minor aches & pains.	Stomach upset
Diphenhydramine (Benadryl) ☐ Yes ☐ No	For minor allergy symptoms, including small rash.	Drowsiness, excitability
Bacitracin (topical antibiotic ointment) ☐ Yes ☐ No	Infection prevention for minor wound care	None significant if administered per manufacturer's instructions
Hydrocortisone 1% cream ☐ Yes ☐ No	For temporary relief of itching	None significant if administered per manufacturer's instructions
Lamisil (Topical antifungal) ☐ Yes ☐ No Tinactin (Topical antifungal) ☐ Yes ☐ No	For treatment of tinea corporis(ringworm). For treatment of tinea pedis.(athlete's foot).	None significant if administered per manufacturer's instructions
Calamine (Lotion) ☐ Yes ☐ No	For temporary relief/protection of irritated skin	None significant if administered per manufacturer's instructions

**Your report of your child's weight will be used to dose medication, if a scale is unavailable. Manufacturer's labels for all OTC medications are maintained by the school nurse for parents/guardians to review upon request.*

III. Parental Permission

By checking the **"yes" box(es)** above, I hereby request that the school nurse administer the above described medication(s) to my child (named above) for the indications listed above while in school or while participating in school curricular activities. I understand that: 1.) There is no liability on the part of the school district agents, including Henderson County Department of Public Health school nurse personnel, for civil damages as a result of the administration of this medication to my child when the nurse administering the medication acts within the scope of nursing practice. 2.) These medications are stocked and maintained by the school with standing orders signed by the medical director of the Henderson County Department of Public Health. 3.) I will be notified of the medication, dosage, and time that over-the-counter medication was administered to my child. 4.) I will be contacted if my child's symptoms do not improve and/or s/he is unable to remain at school.

_____ _____
Parent/Guardian Signature | Date

By checking the **"no" box(es)** above, I hereby indicate that I do not want the specified medications administered to my student.

_____ _____
Parent/Guardian Signature | Date