Administration of Over-the-counter Medication

2024-2025

Dear Parent or Guardian:
To request that Baltimore Lab School administrator over-the-counter medication to your child at school, the following is required:

- The physician's signed dated authorization for selected medication at school.
- Parent signed and dated authorization to administer selected medication at school.
- Physician's directions, if differing from the manufacturer's instructions.
- Annual renewal of authorization and immediate notification, in writing, of changes.

Please take this form to your physician for his/her signature and instructions for administration if differing from manufacturer's instructions.

Name of Student: _____

DOB: _____ /_____ / _____

Over-the-counter medication	Symptoms for which medication is administered	Y/N	Physicians instructions, if differing from product label
Tylenol / Acetaminophen	Headache, fever, muscle aches, pain, menstrual cramps		*Please select dosage on reverse page
Advil / Ibuprofen	Headache, fever, muscle aches, pain, menstrual cramps		*Please select dosage on reverse page
Benadryl / Diphendramine	Runny nose, sneezing, itchy/watery eyes, rash/hives, acute allergic reaction		*Please select dosage on reverse page
Tums / Calcium Carbonate	Heartburn, upset stomach, indigestion		*Please select dosage on reverse page
Cough Drops	Scratchy throat / dry cough		
Neosporin / Antibiotic ointment	Cuts, scrapes, abrasions		
1% Hydrocortisone / anti itch cream	Insect bites, rash, inflammation, itch		
Caladryl	Rash/itch from poison ivy, oak, or sumac		
Burn gel / Lidocaine HCL	Pain associated with minor burns		
Sterile saline solution	Minor eye irritation		
Eucerin Cream	Dry skin		
Sunscreen (when available for field trips)	Sun exposure (please send in personal / labeled supply for your student if needed at recess and/or field trips)		

I request the above student be given the over-the-counter medications above on an as needed basis at school and school activities by qualified staff, according to the manufacturer's instructions or the physician's instructions if they should differ. I/we hereby affirm that I/we am/are aware of the various risks and/or side effects which could be attendant to the over-the-counter medication(s) listed above and hereby knowingly, on behalf of myself/ourselves, my/our child, and all of my/our personal representatives agree to indemnify and hold Baltimore Lab School, its agents and its employees harmless from any liability and/or potential claim(s) that may arise in connection with any adverse reactions, side effects and/or other harm that may result from said student's ingestion/use of those over-the-counter medication(s) indicated above which I/we have authorized Baltimore Lab School to administer to said student.

Parent or Guardian Signature_____ Date_____

Physician Signature _____ Date_____

Physician Printed Name_____ Phone Number_____

Updated 6/2024