BALTIMORE LAB SCHOOL
THE DIFFERENCE IS EXTRAORDINARY

# Over-the-Counter (OTC) Medication Authorization Form

2026-2027

Dear Parent or Guardian:

To request that Baltimore Lab School administrator over-the-counter medications to your child at school, the following is required:

- Physician's directions, if differing from the manufacturer's instructions.
- The physician's signature and stamp with date.
- A parent's signature, date and selected medication you authorize to be given at school.

**Name of Student**: _____ **DOB**: _____/_____/_____

**Known Allergies:** _____

| Over-the-counter medication | Symptoms for which medication is administered | Yes or No | Physicians instructions, if differing from product label |
|---|---|---|---|
| Tylenol/Acetaminophen | Headache, fever, muscle aches, pain, menstrual cramps | | |
| Advil/Ibuprofen | Headache, fever, muscle aches, pain, menstrual cramps | | |
| Benadryl/Diphenhydramine | Runny nose, sneezing, itchy/watery eyes, rash/hives, acute allergic reaction | | |
| Tum/Calcium Carbonate | Heartburn, upset stomach, indigestion | | |
| Cough Drops | Scratchy throat / dry cough | | |
| Neosporin/Antibiotic ointment | Cuts, scrapes, abrasions | | |
| 1% Hydrocortisone | Insect bites, rash, inflammation, itch | | |
| Caladryl/Calmine | Rash/itch from poison ivy, oak, or sumac | | |
| Burn gel/Lidocaine HCL | Pain associated with minor burns | | |
| Sterile saline solution | Minor eye irritation | | |

I request that the student named above be given the listed over-the-counter (OTC) medication(s) on an as-needed basis during school and school-sponsored activities by qualified staff. The medication will be administered according to the manufacturer's instructions, or the physician's instructions if they differ.

I hereby affirm that I am aware of the various risks and potential side effects associated with these medication(s). On behalf of myself and the student, I knowingly agree to indemnify and hold Baltimore Lab School, its agents, and its employees harmless from any liability, claims, or demands arising from any adverse reactions, side effects, or other harm resulting from the student's use or ingestion of the authorized OTC medication(s).

Parent or Guardian Printed Name: _____
Parent or Guardian Signature: _____ Date: _____

Physician/Healthcare Provider Printed Name: _____
Physician/Healthcare Provider Signature: _____

Date: _____ Phone Number:_____

Updated 7/2026