

ADMINISTRATION OF OVER-THE-COUNTER MEDICATION School Year 2018 - 2019

Dear Parent or Guardian:

To request that Baltimore Lab School administer 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 dated authorization to administer selected medication at school.
- Physician's directions, if differing from 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	Physician's 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		
Claritin/Loratidine	Runny nose, sneezing, itchy/watery eyes		
Tums / calcium carbonate	Heartburn, upset stomach, indigestion		
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: _____ **Date:** _____

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

Physician's Printed Name/Title: _____ **Phone:** _____