School: _____

Phone: _____ **Fax:** _____

POLICY FOR OVER-THE-COUNTER MEDICATION IN SCHOOL

Over-the-counter medications listed on the Consent for Administration of Over-the-Counter Medications Form will be dispensed only if BOTH the medical provider and the parent/guardian sign and date the form. We will not dispense over-the-counter medication without the signed consent on file. If you do not wish for your child to receive over-the-counter medication at school, please sign the form and check the box indicating, "I do not wish my child to receive any over-the-counter medications at school." A medical provider does NOT need to sign the form if over the-counter-medication will not be given.

If your child is to receive any over-the-counter medication that is not listed on the Consent for Administration of Over-the-Counter Medications Form, please complete The MARYLAND STATE SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM, available at https://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SHS/medforms/medicationfo rm404.pdf.

Parents/guardians must hand-deliver any over-the-counter medications directly to the School Nurse. Over-the-counter medication must be brought to school in an original, unopened container and labeled with the student's name and homeroom. Students are not permitted to self-carry over-the-counter medications.

If you have any questions, please contact the school nurse.

Thank you!

School: _____

Phone: _____ Fax: _____

CONSENT FOR ADMINISTRATION OF OVER-THE-COUNTER MEDICATIONS for School Year_____
(Must be renewed each year.)

Student's Name: _____ Grade: _____ Date of Birth: _____

Weight: _____lbs._____kg (if needed for dosage) Allergies: _____

Medication currently receiving:

_____

__Parents/guardians must provide medication to School Nurse in the original, unopened container labeled with their student's name and homeroom. All medications must be hand delivered to the School Nurse by an adult, not sent in with student.__**

Check all medications that may be given and specify dose and frequency in the chart below. If you prefer that no over-the-counter medications be administered to your child at school, please check the box below.

	Medication	Reason	Dose	Route	Frequency	Side Effects
□	**Ibuprofen/ Motrin**					
□	**Acetaminophen/ Tylenol**					
□	**Diphenhydramine/Benadryl**					
□	**Antacid Tablets/ Tums**					
□	**Cough Drops**					
□	**Antibiotic Ointment**					
□	**Anti-itch Lotion/Cream (Hydrocortisone, Calamine)**					
□	**Aquaphor, Eucerin**					

Note any special instructions for medications to be given (e.g. take with food): _____

_____

Please note **School policy does not permit the student to self-carry the over-the-counter medications.**

□ I do not wish my child to receive any over-the-counter medications at school. (No Doctor's Signature is required.)

Parent/Guardian Signature: _____ **Date:** _____ **Phone:** _____

Doctor's Signature: _____ **Date:** _____ **Phone:** _____

School Nurse Signature: _____ **Date:** _____ **Phone:** _____