St. Joseph School
CONSENT TO ADMINISTER OVER THE COUNTER MEDICATIONS AT SCHOOL

Student Name_____

Drug Allergies_____

The following medications are kept in the office for **occasional student use**.

Please initial the medications that you give permission for your child to have.

____ Acetaminophen (Tylenol) As per package instruction for use, indications, frequency & dose

_____Ibuprofen (Advil) As per package instruction for use, indications, frequency & dose

_____Antacids (Tums) 250-500 mg tablet (stomach upset)

_____ Hydrocortisone Cream (for rash/itching)

_____ Diphenhydramine (Benadryl) as per package instruction for dosage; for signs/symptoms of allergic reaction only

I understand that any school employee who administers these medications according to proper dosages listed on the label shall not be liable for damages as a result of an adverse reaction to the medication administered. I hereby give permission for my child named above to receive medication checked on this form as deemed necessary by the school nurse or staff. A parent will be notified via FACTS or email if their student receives medication. This form applies for the time my student remains at St. Joseph School unless a parent changes this in writing.

_____ _____

Signature of parent/legal guardian **Date**

_____ _____

Signature of Provider **Date**