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Student: \_\_\_\_\_ Birthdate: \_\_\_\_\_

I give permission for my child, \_\_\_\_\_, grade \_\_\_\_\_, to receive non-prescription medication at school if necessary to relieve minor pain and discomfort.

Please mark each medication/generic equivalent your child may receive at school. Dosage will be appropriate as per manufacturer's directions or as directed by parent or guardian. Medications will only be dispensed by Nurse Chris or designated school staff. Any medications taken routinely at school will need a separate medication consent form completed and signed by the student's parent/guardian and medical provider.

Please list any known medication allergies: \_\_\_\_\_

*State Law requires parent/guardian permission before school health staff can provide any stock medication at school.*

MEDICATION	YES	NO
<b>Pain Relievers</b>		
Regular Strength and Children's chewable-		
Tylenol/Acetaminophen		
Ibuprofen fever/pain reducer		
<b>Antacids</b>		
Tums		
<b>Cough Drops</b>		
Cough Suppressant (Syrup)		
Cough drops		
<b>Sinus Medication</b>		
Benadryl/Diphenhydramine 12.5mg-		
chewable tablets		
Benadryl/Diphenhydramine 25mg		
<b>Topical/First Aid Creams</b>		
Anti-Itch Gel (Diphenhydramine HCL 2%)		
Alcohol		
A&D Cream		
Burn Relief Gel		
Neosporin Ointment		
<b>Chapped Lips/Skin</b>		
Vaseline		
Lip Balm		
<b>Eye Drops</b>		
Refresh Plus Lubricant Eye Drops		
<b>Oral discomfort</b>		
Oral Pain Relief Gel (Benzocaine 20%)		
<b>Procedure/Treatment</b>		
Tick removal		
Splinter Removal		

\*\*\*Please see back of document for signature\*\*\*

**As the parent or guardian of the above mentioned student, I will keep the school district aware of any changes in medication(s) or health concerns for my child.**

I hereby give permission to designated school personal to give medication or to administer the above mentioned remedies to my child during the school day, including when away from school property on official school business. I hereby give personal to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication. I further agree to hold the Princeton School District, and the employee(s) acting on this request, harmless on any or all claims arising from the administration of this medication at school.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_