PARENTAL PERMISSION FOR OVER THE COUNTER MEDICATION

Last Name ___________________________   First Name ___________________________   ____/____/____   ___/____/____  Grade  Home Room

The school nurse has a limited supply of over the counter medication that may be dispensed with written parental permission. Students requesting medication must be evaluated by the school nurse and may receive medication for minor muscle aches and pains or discomfort due to the common cold, headache, toothache or menstrual cramps. The school nurse may contact you to discuss the frequency of your child's request for medication, or to recommend follow up care with your health care provider. This form must be completed in full each school year by a parent or guardian. All other over the counter medications must be approved by the nurse and supplied by the parent or guardian.

Check off each medicine that you give permission for your child to receive, and CROSS OUT any that should not be given.

- acetaminophen (generic Tylenol) per label directions
- ibuprofen (generic advil) per label directions
- anti-itch creams (hydrocortisone based)
- anti-itch lotions (pramoxine based -generic calamine)
- menthol cough drops
- antibiotic ointments for minor cuts and scrapes

I give permission for the school nurse, a substitute nurse, or any other member of the school staff designated by the principal, to administer the medications that are checked off above. By signing this form, I agree to hold harmless and indemnify the Salem School District and any staff member for any and all losses that may be occasioned as a result of taking this medication, including adverse reactions. I understand that the use of ibuprofen or acetaminophen is limited to three doses in one month and a doctor's evaluation and medication order will be required if my child needs to take analgesics more frequently.

Date____ /____ / _____  Signature

HEALTH HISTORY This history form must be filled out in full each school year.

Date of your child's last complete physical: ____/____/____  Doctor:________________________________________

List any serious food, drug or other allergies ____________________________

What reaction does the allergy cause? ____________________________

Has your child ever been diagnosed with asthma?  yes  no  Uses inhaler  daily  often  never

Is your child currently under treatment for any physical or mental health conditions?  yes  no

Diagnosis: __________________________________________

Medicines taken on a daily basis at home: ____________________________

Has your child had any hospitalizations or broken bones in the past year? yes  no  If yes, explain ____________________________

Do you give permission for your child to participate in confidential health screening for growth and back problems? (This screening is mandated by the State Board of Education and is conducted in privacy.)  yes  no

Do you give permission for the above health information to be shared with your child's classroom teachers? yes  no

Do you give permission for the school nurse to contact your child's doctor? yes  no

Date____ /____ / _____  Signature

Revised 7/02; 12/06