



Parental and Physician Authorization for Dispensing Over-the-Counter Medication 2024-2025

Student's Name: _____ Date of Birth: _____

The school nurse may administer the following medications as deemed appropriate. The medications listed below will be available in the School Nurse's office. These medications will be administered by the manufacturer's recommended dosing for weight and/or age.

Medication	Route	Dosage	Common Side Effects	Indications & Schedule	May be Administered?
Children's Tylenol (Acetaminophen) - Chewable	By mouth	Per label instructions weight and/or age	Nausea, vomiting, no significant side effects if administered per label	For pain or fever* every 4-6 hours as needed	<input type="checkbox"/> YES <input type="checkbox"/> NO
Children's Motrin (Ibuprofen) - Chewable	By mouth	Per label instructions weight and/or age	Upset stomach	For pain or fever* every 4-6 hours as needed	<input type="checkbox"/> YES <input type="checkbox"/> NO
Children's Benadryl (Diphenhydramine HCL) - Liquid	By mouth	Per label instructions weight and/or age	Drowsiness	For allergic reaction every 4-6 hours *Complete an Allergy Action Plan for known allergies	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bacitracin Antibiotic Ointment	Topically	Bacitracin 500u	Irritation	Minor cuts, 1-3 times daily	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hydrocortisone Cream 1%	Topically	Hydrocortisone Cream 1%	Burning/stinging	Bug bites, minor skin irritations or rashes, up to 4 times daily	<input type="checkbox"/> YES <input type="checkbox"/> NO
Children's Allergy Medication (ie Zyrtec, Claritin)	By mouth	Per label instructions weight and/or age	Drowsiness	For seasonal allergies	<input type="checkbox"/> YES <input type="checkbox"/> NO

*Will not be given after head injury. May be given for fever while awaiting caregiver pick-up.

Does the student have any allergies? No Yes: _____

Does the student take any medication at home? No Yes: _____

A new form must be submitted if any changes to preferences are made throughout the school year. This form must be renewed annually and signed by both the parent and healthcare provider to be considered valid. The signature below indicates you have read and approved this consent form:

Parent/Guardian Signature: _____ Date: _____

Parent signature only if no permission for OTC medication

Health Care Provider Signature: _____ Date: _____

A health care provider's permission is required by New York State for a nurse to administer OTC medication at school

Healthcare Provider Stamp	
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