Spearfish School District 40-2

Permission for "Occasional" Over-the-Counter (OTC) Medication Grades K-5

Student_____Grade_____School_____

Medication Allergies_____

Current Daily Medications (please include dose, time and prescribing physician)

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You may choose to provide permission for your child to receive the following OTC medications in the school setting per the below protocols.

□ Acetaminophen (Generic Tylenol)	Fever, headache, toothache, sore throat, muscle pain, earache.
□ Ibuprofen (Generic Advil)	Fever, headache, toothache, sore throat, muscle pain, earache.
□ Cough Drops	Temporary relief of cough, pain associated with sore throat.
□Triple Antibiotic Ointment (Neosporin)	First aid to help prevent infections in minor cuts, scrapes, abrasion, and rashes.
□ Aquaphor	Dry, chapped, irritated skin
□ Anti-Itch cream/spray (hydrocortisone 1%, Benadryl, or caladryl)	Relief of itching due to skin rashes and or insect bites.
□ Antihistamine (Zyrtec, Benadryl)	For systemic reaction characterized by rash, edema, and or mild to moderate respiratory distress due to environmental, food or insect allergies. Parents will be notified. Further emergency care will be facilitated as warranted by condition.
□ Children's pepto	Stomach upset, indigestion.
□ Orajel	Temporary relief of toothaches and other minor irritation of mouth.

All medications will be dispensed according to label instructions for dosing and frequency at the discretion of the RN. Students' weights may be obtained as necessary for accurate dosing.

The school is not able to supply medication for frequent or daily use. Any other medications not included in the above list, or medications that must be given on a regular basis, can be administered to your child but must be provided and presented in the original container.

All prescription medications require additional written permission of the parent/guardian for administration in the school setting.

I hereby certify that my child has had at least one dose of the medication(s) requested. I understand that any school employee who administers this medication to my child will do so in accordance with the Practice Act of the SD State Board of Nursing. I release and waive any and all claims which I now have or may hereafter have against the Spearfish School District 40-2 and its employees arising out of the administration of or failure to administer the medication to the student or adverse reaction by the student to the medication.

Signature of Parent/Guardian_____

Printed Name_____Date_____