

Seton Keough High School  
CONSENT FOR ADMINISTRATION OF "OVER-THE-COUNTER"  
MEDICATIONS

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Medication Allergies \_\_\_\_\_

List any medications this student receives regularly \_\_\_\_\_

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**Please check any medication(s) you wish to be made available to your child under nursing discretion:**

For headache/fever/muscle aches/menstrual cramps:

- Tylenol, 1 or 2 – 500mg tabs every 4-6 hours
- Ibuprofen, 1 or 2 – 200mg tabs every 4-6 hours

For mild cold symptoms:

- Suphedrine PE, 10mg tab every 4-6 hours
- Cough Drop, 1 or 2 for mild throat discomfort, mild cough

For mild stomach discomfort:

- Antacid, 2 tabs (Tums, Pepto-Bismol)

For mild allergic reactions (such as hives):

- Benadryl, 1 or 2 – 25mg tabs every 4-6 hours

For mild skin irritation:

- Hydrocortisone cream 1% for minor skin irritations and rashes due to dermatitis, poison ivy/oak, insect bites, soaps and detergents
- Antibiotic ointment (Neosporin) for minor cuts and abrasions
- Burn Spray (lidocaine base) for mild burns, sunburn

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I give permission for my child \_\_\_\_\_ to receive any medications indicated above as deemed necessary by the school nurse. I understand that generic equivalent medications may be used in place of brand-name items.

I DO NOT WANT ANY MEDICATION GIVEN TO MY CHILD IN SCHOOL.

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

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

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