THE LEHIGH VALLEY CHARTER HIGH SCHOOL FOR THE ARTS

## AUTHORIZATION FOR OVER-THE-COUNTER MEDICATION ADMINISTRATION DURING SCHOOL HOURS

Dear Parent/Guardian:

In order for your child to receive over-the-counter medications during the school day, you must complete this form. The following over-the-counter medications are approved by the School Physician. This form must be completed and signed by a parent/guardian every school year for students to receive these medications while they are in school.

**MEDICATION WILL NOT BE DISPENSED UNLESS THIS FORM IS ON FILE FOR CURRENT SCHOOL YEAR.**

I am the Legal Parent/Guardian of the following Student:

Name of Student (print):_____Grade: _____

**Allergies:** _____Date:_____

Medication will be dispensed for minor discomforts including, but not limited to - menstrual pain, headaches, dental pain, skin irritations, minor cuts or injuries. If your child repeatedly requests pain relieving medication (more than 3 times in a 30 day period), we will contact you with a request that the child receive a medical evaluation by their Health Care Provider.

Please place an X for each medication you approve:

_____Benadryl Liquid 25 mg (10 ml) **for allergic reactions only-not for seasonal allergies**

_____ Ibuprofen ("Advil") 200mg to 400mg once during school day

_____Acetaminophen ("Tylenol") 325mg to 650mg once during school day

Tums (antacid) 2 tablets for heartburn/upset stomach/indigestion once during school day

_____Chloraseptic sore throat lozenges 1 every 2 hours throat irritation/Cough drops 1-2 for cough

_____Anbesol for toothaches, gum pain, and mouth sores

_____Caladryl (anti-itch) lotion applied to bug bites, poison ivy rash, and skin rashes

_____Burn spray or gel to minor burns

_____Lubricant eye drops for eye irritation/dryness

_____Bacitracin antibiotic ointment for open wounds (cuts, abrasions, etc.)

_____Sting Swabs applied to insect bites/stings

I authorize the Nursing Personnel of the Lehigh Valley Charter High School for the Arts to provide my child the over-the-counter medications I have checked, after appropriate assessment and evaluation. Nursing personnel reserve the right to refuse to provide a medication based upon individual assessment of the student.

___ _____Name of Parent or Legal Guardian (print)

_____Signature of Parent or Legal Guardian