Cedar Bluffs Public Schools

Over-The-Counter (OTC) Medication
Parental Permission and Instruction Form

Name(s):_____has/have
Permission to take the following OTC medication(s) on an as needed basis:

Note: You must indicate which OTC medication your child/children can take as well as the dose and amount for each child.

_____	Ibuprofen (Advil, Motrin)	200 mg.	____**1 or** ____**2**	every 4 hours.
_____	Acetaminophen (Tylenol)	325 mg.	____**1 or** ____**2**	every 4 hours.
	OR	500 mg.	____**1 or** ____**2**	every 4 hours.

I understand that doses over the amount listed on the label cannot be given without a written order from a licensed healthcare provider (MD, PA, Dentist, Nurse Practitioner, etc).
I will provide any OTC medication for my child/children. Family members may share a bottle.

The above medications may be taken for the following symptoms/complaints: **(Check all that apply.)**

_____ Headache _____ Back Pain _____ Menstrual Pain

_____ Muscle or body aches _____ Other (Please explain below.)

Other medication my child/children may take with complete directions: (Examples: decongestants, cough medicines, antacids. "Mary may take Sudafed 30 mg. Two every 4 hours if she needs to for a sinus headache. She can take Tylenol with the Sudafed.")

_____
_____
_____

This form will be kept on file for the school year.
I understand that it is my responsibility to notify the school if my child/children become unable to take any of these medications during the school year. I understand that it is my responsibility to monitor the effects of these medications as well as possible side effects/adverse reactions for my child/children.

_____ _____
Parent/Guardian Signature Date

Revised 6/2003 L. Hardy, RN, MSN