Paradise Valley Unified School District

## OVER-THE-COUNTER MEDICATION PERMISSION/RECORD (Middle/High Schools)

**School Year** _____/_____

**Student Name** _____ **Grade** _____

In case of minor injury or illness during the school day, I authorize the school nurse to be my agent to give my child the dosage of medication(s) listed based on weight/age and given in compliance with manufacturer's recommended dosage label. I understand that alternate methods of care will be used before medication is given (i.e., eating lunch, resting, etc.).

I further understand that if my child needs other medication(s) for an extended period of time or for a chronic health condition, I must supply the medication(s) in its original pharmacy container and complete a separate medication permission form for each medication.

I agree to, and do hereby hold the district and its employees harmless from any and all claims, demands, causes of actions, liability, or loss of any sort, because of or arising out of acts or omissions with respect to this medication.

Administration of any of the following medications is at the professional discretion of the school nurse and may only be administered by the school nurse or a qualified substitute nurse.

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**PLEASE CHECK ☑ THE MEDICATIONS YOU ARE AUTHORIZING FOR ADMINISTRATION**
**Medication(s) supplied by parent/guardian must be in its original prepackaged container.**

**Tylenol® (Acetaminophen)**
- ☐ Adult 500 mg tablet
- ☐ Adult 325 mg tablet
- ☐ Children's chewable 80 mg tablet

**Motrin®/Advil® (Ibuprofen)**
- ☐ Adult 200 mg tablet
- ☐ Children's chewable 50 mg tablet

**Benadryl® (Diphenhydramine)**
- ☐ Tablet 25 mg

**Tums® (Calcium Carbonate)**
- ☐ Tablet 500 mg

- ☐ Caladryl Lotion
- ☐ Calamine Lotion
- ☐ Hydrocortisone Cream
- ☐ Cough Drops
- ☐ Benzocaine (Orajel™)

ISE-HS-003 Mid/High (Rev 03/2018)

**Signature of Parent/Guardian** _____ **Date** _____

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ISE-HS-003 Mid/High (Rev 03/2018)

Signature of Parent/Guardian _____ Date _____

## OVER-THE-COUNTER MEDICATION PERMISSION/RECORD (Middle/High Schools)

**Student Name** _____ **Grade** _____

| OTC Medication Given | Date | Time | Given By | OTC Medication Given | Date | Time | Given By |
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**Nurse's Signature** **Initials**

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## OVER-THE-COUNTER MEDICATION PERMISSION/RECORD (Middle/High Schools)

**Student Name** _____ **Grade** _____

| OTC Medication Given | Date | Time | Given By | OTC Medication Given | Date | Time | Given By |
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**Nurse's Signature** **Initials**

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ISE-HS-003 Mid/High (03/2018) **Paradise Valley Unified School District**