



A NEW FORM IS NEEDED EACH SCHOOL YEAR

OVER-THE-COUNTER PERMISSION/AUTHORIZATION FORM

The Over-the-Counter Medication Permission/Authorization Form is to be completed, signed and returned to Mercy High School by the first day of orientation. Part I is to be completed (check yes or no) and signed by a parent/guardian. Part II is to be completed and signed by your daughter's physician. No medications of any type will be given to your daughter until this form, Part I and Part II, is completed and on file in the Health Office. It is school policy and state law that no student may carry or take any medications unless under the supervision of the school nurse/school administrators.

PART I: Parent Consent for Administration of Over-the-Counter Medication

Student's Name _____ Year of Graduation _____

Known Allergies _____

Medications Taken Regularly _____

Check the over-the-counter medications listed below that you wish to be available to your daughter in school.

- 1. Acetaminophen (generic Tylenol) Yes ___ No ___
2. Ibuprofen (generic Advil) Yes ___ No ___
3. Antacid (generic Tums) Yes ___ No ___
4. Cough Drops Yes ___ No ___
5. Neosporin bacitracin ointment Yes ___ No ___
6. Hydrocortisone cream .5-1% Yes ___ No ___
7. Benadryl Yes ___ No ___

I give permission for my daughter to receive the above medications that I have checked during school hours to be administered by the school nurse.

Parent/Guardian Please PRINT Clearly

Parent/Guardian Signature

Part II: Physician Authorization Form for Over-the-Counter Medications

Student's Name _____

- 1. Acetaminophen (325 mg) 1-2 tabs po q4hr pm (for headache, fever, mild muscle discomfort, menstrual cramps) Yes ___ No ___
2. Ibuprofen (200 mg) 1-2 tabs q4-6 hr prn (for headache, mild to moderate muscle discomfort, menstrual cramps) Yes ___ No ___
3. Antacid (Tums) 1-2 tabs po (for mild to moderate gastric hyperacidity) Yes ___ No ___
4. Cough drops 1-2 po prn (for mild throat irritation or cough) Yes ___ No ___
5. Bacitracin/Neosporin ointment topical (for minor cuts, skin abrasions) Yes ___ No ___
6. Hydrocortisone cream 0.5-1% topical (for insect bites, mild rashes) Yes ___ No ___
7. Benadryl 25 mg to 50 mg po q4-6 hrs prn (for allergic reactions) Yes ___ No ___

Physician's Signature

Date

*Stamp physician name, address and phone number here.