Grand Meadow School Health Office

Authorization for Over-the-Counter (OTC) Medications & Basic Health Services

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Student Information

Student Name: _____

Date of Birth: _____ **Grade:** _____

Medical Information

Does your child have any medication allergies or medical conditions the school should be aware of?

☐ No

☐ Yes (Please list medication(s)): _____

☐ Yes (Please list medical condition(s)): _____

Authorization for Over-the-Counter (OTC) Medications

Please check the medications you authorize school personnel to administer according to school policy and manufacturer-recommended dosing based on your child's age and weight.

Medication	Yes	No
Acetaminophen (Tylenol®)	☐	☐
Ibuprofen (Advil®, Motrin®)	☐	☐
Antacid (Tums® or equivalent)	☐	☐
Cough drops (age appropriate)	☐	☐
Antibiotic ointment (for minor cuts/scrapes)	☐	☐
Hydrocortisone cream (1%)	☐	☐
Anbesol (for mouth pain)	☐	☐
Oral antihistamine (if allowed by school policy)	☐	☐
Artificial tears/eye lubricant	☐	☐
Chloraseptic Lozenges (for sore throats)	☐	☐
Other (Specify): _____	☐	☐

Authorization for Basic Health Services ☐ Yes ☐ No

I authorize trained school personnel to provide routine health services and basic first aid, including but not limited to:

- Cleaning and covering minor cuts and scrapes
- Applying adhesive bandages
- Applying ice packs for minor injuries
- Taking temperature when appropriate
- Removing splinters when possible
- Assisting with minor nosebleeds
- Basic first aid for minor injuries

Parent Acknowledgment

I understand that:

- OTC medications will only be administered by authorized school personnel when appropriate and in accordance with school standing orders.
- Medications will be given according to manufacturer recommendations or school protocols.
- The school will attempt to contact me when appropriate, but treatment may be provided before contact for routine care.
- If my child's condition appears serious or requires emergency medical attention, school personnel will follow emergency procedures, including contacting emergency medical services (911) when necessary.
- If my child is found to have frequent requests for medication/treatment, I will be asked to have my child assessed by a doctor; if other medication is needed a signed medication order form will need to come from the doctor's office.
- I may revoke this authorization at any time by providing written notice to the school.

Parent/Guardian Signature

I give permission for the health services and OTC medications indicated above.

Parent/Guardian Name (Print): _____

Signature: _____

Date: _____

School Use Only

Date Received: _____Reviewed By: _____

Comments: