School Year: 20____ - 20____
New forms must be completed every year.

Permission to Administer Over-the-Counter Medication
Valley Center Public Schools
Health Service Department

Student Name: _____ Date of Birth: _____ Grade: _____
Weight: _____

Board Policy: OVER-THE-COUNTER (OTC) MEDICATION WILL BE GIVEN AT SCHOOL ONLY UPON WRITTEN REQUEST FROM THE LAWFUL GUARDIAN. THIS WRITTEN REQUEST IS REQUIRED BEFORE ADMINISTRATION OF MEDICATION IS INITIATED.

OTC medications must be provided by the guardian in the original container and will be given per label instructions unless otherwise indicated by a physician. Additionally, the student must have taken the OTC medication previously without adverse reaction. OTC medications that will require a physician order include homeopathic/herbal medications and aspirin (or medications containing aspirin). All OTC medications will be given on an as needed basis and a physician order will be needed if the medication is needed daily (scheduled). These medications must be stored in a locked cabinet in the health room.

***Acetaminophen and Ibuprofen will not be given together without a physician's order. Please choose and send one or the other.**

OTC Treatment Permission: Please mark (x) by each OTC you approve of for use for your child.

Topical Medication: Purpose for use:	Oral Medication: Purpose for use:
☐ Hydrocortisone Cream-	☐ Acetaminophen (Tylenol)-
☐ Calamine lotion-	☐ Ibuprofen (Advil, Motrin)-
☐ Lotion-	☐ Antacids (Tums or equivalent)-
☐ Cooling burn gel-	☐ Cough drops or Lozenges-
☐	☐ Cough Syrup-
☐	☐ Eye drops-
☐	☐ Antihistamine-
☐ Other:	☐ Other:
☐ Other:	☐ Other:

Dose Instructions

_____

Special Instructions

_____

Child has taken the above medication(s) previously without an adverse reaction: Yes No

I relieve Valley Center USD 262 of any responsibility for the consequences of administering the requested OTC medication and acknowledge that the school incurs no liability for damage, injury, or death resulting directly or indirectly from the administration of the requested OTC medication.

Parent/Guardian Name: _____

Phone:_____

Parent/Guardian Signature Date

_____