

Winchester Community School District #1

Grade School

Phone #: (217) 742-9551

Fax #: (217) 742-0014

High School

Phone #: (217) 742-3151

Fax #: (217) 742-0311

Over-the-Counter Medication Form 2019-20

Student Name: _____ DOB: _____ Grade: _____

Allergies (Medication, Food, Other): _____

Daily Medication(s) & Dosage(s): _____

I hereby authorize the school nurse (only on days when she is present at my child's school), or the School Administration, to administer over the counter medication to my child as prescribed by standing orders as indicated below. I understand that if my child visits the nurse multiple times with the same complaint, I will be contacted, and my child will be referred to his/her medical provider for evaluation. If any adverse reaction to medication is noted I will be notified immediately. In case of severe reactions, I give permission for my child to receive emergency care. I hereby release the Board of Education, their agents, and employees from any and all liability that may result from my child taking medication. This permission form is valid for the current school year only.

Physician's _____ **Name/Signature:** _____ **Date:** _____

Parent/Guardian's Signature: _____ Date: _____

<u>Over-the-Counter Medication</u>	<u>Condition/Symptoms</u>	<u>Dosage/Time</u>	<u>Possible Side-Effects</u>
Antacid (Tums) Chewable Tablets (Calcium Carbonate) <input type="checkbox"/> Yes <input type="checkbox"/> No	For stomach ache or heartburn.	Administer according to the manufacturer's label.	Constipation. *Not to be used in children less than 6 years old.
Advil/Motrin Liquid or Tablet (Ibuprofen) <input type="checkbox"/> Yes <input type="checkbox"/> No	For relief of body aches and pains, menstrual cramps, or fever.	Administer according to the manufacturer's label.	Upset Stomach. * Contains no aspirin but should not be given if student has allergy to aspirin; may cause stomach bleeding.
Tylenol Liquid or Tablet (Acetaminophen) <input type="checkbox"/> Yes <input type="checkbox"/> No	For relief of minor aches and pains; fever.	Administer according to the manufacturer's label.	None significant if administered per manufacturer's label.
Benadryl Liquid or Tablet (Diphenhydramine) <input type="checkbox"/> Yes <input type="checkbox"/> No	For allergy symptoms.	Administer according to the manufacturer's label.	Drowsiness or excitability. *Students will not be allowed to drive within 4 hours of taking it.
Triple Antibiotic (Cream/Ointment) <input type="checkbox"/> Yes <input type="checkbox"/> No	For scratches, burns, scrapes, etc.	Administer according to manufacturer's label.	None significant if administered per manufacturer's label.
Hydrocortisone (Cream or Spray) <input type="checkbox"/> Yes <input type="checkbox"/> No	Redness, rash, or itching.	Administer according to manufacturer's label.	Skin itching, burning, or redness.
Cough Drops <input type="checkbox"/> Yes <input type="checkbox"/> No	For sore throat or cough.	Administer according to manufacturer's label.	None significant if administered per manufacturer's label.

