Cornerstone Christian Academy

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Parent Permission for Dispensing Over-the-Counter Medications for School Year 20___/___

The following over-the-counter medications will be given only with parental permission. Please sign your name next to the listed medications giving permission for administration of these medicines during the school year. ***Please read carefully before signing***.

I give permission for (CHILD'S NAME)_____ DOB____/____/____ to take the following non-prescription medication under the supervision of the school nurse or designated staff member. I will indemnify and hold harmless any member of the school staff so designated to give this non-prescription medication. **Student's estimated weight to be used for dosage amount _____**

<u>Oral Medications</u> require a signature for approval. Cornerstone will not dispense OTC Medications without verbal parental/guardian consent before administering.

_____Acetaminophen for fever/headache/pain

_____Ibuprofen for fever/headache/pain

_____Tums/Rolaids for acid indigestion, sour/upset stomach

_____Pepto Bismol for upset stomach

_____Benadryl for allergic reaction/allergy relief

The administration of the above listed medications will be documented.

<u>Other medications:</u> (Please initial any of the following you give permission to administer as needed)

_____ Eye Drops for eye irritation/allergies

_____ Calagel/Calamine Lotion for rash or itch

_____ Hydrocortisone for skin irritation/rash or itch

_____ Anbesol liquid for tooth pain/canker sore

_____ Blistex/Chapstick/Vaseline for chapped lips

_____ Bacitracin or Neosporin ointment for abrasions, minor cuts

_____ Cough Drops

_____ Alcohol/Hydrogen Peroxide

_____ Band-Aid AntisepticWash

_____ Benadryl Lotion for rash or itch

_____ Moisturizer for chapped skin

_____ Sting Relief for insect bites

_____/_____/_____

Parent Signature (Print Parent Name) (Daytime Contact #) (Date - MM/DD/YYYY)

_____/_____/_____

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