Boyne Falls Public School: *Non-Prescription* Medication Authorization

Revised: 03-01-2024

The following information is required for administration of NON-PRESCRIBED medications in school. *This form is valid for one school year.*

Student Full Name:_____Date:_____

School Year**:**_____ Grade:_____Date of Birth:_____Student Age:_____

Allergies:_____

Medical history:_____

Please initial which medication(s) the above named student is *ALLOWED* to have administered by Boyne Falls Public School personnel:

_____Acetaminophen (Tylenol) 325 mg tablet, 1-2 tabs by mouth every 4 hours as needed for pain.

_____Children's acetaminophen (Tylenol) chewable 160 mg per tab, number of tabs given per age/weight per bottle by mouth every 4 hours as needed for pain.

_____Ibuprofen (Motrin) 200 mg tablet, 1-2 tablets by mouth every 6 hours as needed for pain.

_____Children's Ibuprofen (Motrin) chewable, 100 mg tablet, number of tabs given per age/weight per bottle by mouth every 4 hours as needed for pain.

_____Benadryl, 25 mg tablet, ½ -1 tablet given every 6 hours as needed for allergic reactions or allergy symptoms.

_____Children's Benadryl chewable, 12.5 mg tablet, 1 tablet by mouth every 6 hours as needed for allergic reactions or allergy symptoms.

_____Calcium Carbonate (TUMS) 1-4 chewable tablets as needed for heartburn, upset stomach, indigestion.

_____Hydrocortisone Cream topical ointment/anti itch cream applied as needed but not more than 3 times per day to the affected area.

_____Oral anesthetic (Orajel or Anbesol) applied to the affected area as needed but not more than 4 times in 24 hours as needed for oral pain such as canker sores, toothaches, etc.

_____Cough Drops; ***should be provided by the parent and will be labeled with the student's name and kept in the main office for administration-no cough drops are allowed in backpacks, lockers, or classrooms.***

_____ Any other non-prescription medication that is not listed above and will be provided to the school for the above named student. Medication Name_____ Medication dosage_____ Medication reason_____

Please read and initial the following statements below signifying that you agree:

_____I will assume responsibility for safe delivery of the medication to school. Students must not transport medication for safety reasons.

_____I am requesting my child be administered this over the counter medication at school by school personnel per the directions above.

_____I will notify the school immediately if there is any change in the use of the medication.

_____I will provide any medication that the above named student may need frequently.

_____I release and agree to hold the Board of Education, its officials, and its employees harmless from any liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

Parent/Guardian initial:_____ Date: _____ Parent/Guardian daytime phone: _____

Parent/Guardian Signature: _____