Bishop Ireton High School
Over-the-Counter Medication Form

The school nurse will assess your child and pertinent comfort measures may be utilized before medication is administered. Only the school nurse or her licensed designee may administer any medications, based on nursing judgment and as instructed on the label.
Please complete and return to school health clinic. No medications will be administered without this form on file in the clinic. Verbal orders are NOT acceptable. Fax copies are acceptable. A new form is needed each school year.

Student name_____Date of birth _____
Last first

List any Medication Allergies_____

The school nurse may give my child: (check all that apply) These medications are stocked in the clinic.

□ **Tylenol/ acetaminophen 325mg** □ **1 tablet** □ **2 tablets**

□ **Advil/Motrin/ ibuprofen 200mg** □ **1 tablet** □ **2 tablets**

□ **Tums** □ **2 tablets chewed** □ **3 tablets chewed**

□ **cough drops**

If my child has: (check all that apply)

□ **Pain** □ **Upset Stomach** □ **Cough** □ **Other _____**

I hereby request designated school personnel to administer over-the-counter medication as directed by this authorization. I agree to release, indemnify, and hold harmless the designated school personnel from lawsuits, claim expense, demand or action, etc., against them for helping the student use the above medication, provided the designated school personnel comply with the orders set forth by the parent/guardian.

Parent or Guardian Signature **Date**