

**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)

- Tylenol/ acetaminophen 325mg 1 tablet 2 tablets
 Tylenol/ acetaminophen 500mg 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