Rangeley Lakes Regional School District
PERMISSION TO ADMINISTER MEDICATION AT SCHOOL
2014-2015 School Year
(Please complete and return to school nurse)

The following medications may be administered at school with written parental/guardian permission. *(For medication not on this list physician's permission is also required, see handbook for more information).*

I give permission for my child _____ grade _____ to be
(Print student's name here)
given the following medications according to manufactures guidelines. I understand that when the nurse is not available the medication may be administered by trained, non-medical school personnel.

Please circle yes or no to the following, initial each entry and sign at the bottom:

Tylenol (acetaminophen)…….....Yes / No _____ (initial)
For headaches, earaches, minor injury, minor illness, menstrual cramps, dental or orthodontic procedures and fever reducer.

Advil (Ibuprofen)……..Yes / No _____ (initial)
For headaches, menstrual cramps, back aches, muscle aches, fever reducer, earaches, and toothaches.

Tums…… Yes / No _____ (initial)
For minor gastric upsets or minor heart burn.

Caladryl Clear Lotion Yes / No
Hydrocortisone Cream……. Yes / No _____ (initial)
For minor itchy rashes or skin irritation.

Aloe Vera Gel ……Yes / No _____ (initial)
For minor sunburns

Bacitracin ointment……. .Yes / No _____ (initial)
On minor cuts, wounds or abrasions if no known allergy to this product exists.

BIOFREEZE pain reliever **(gr 6-12 only)** Yes / No _____ (initial)
Topical cold therapy pain relief to treat athletic and muscle related injuries, sore or strained muscles, back pain, ankle/foot pain, sports injury pain.

Cough drops / throat lozenges……...Yes / No _____(initial)
Cough drops are given sparingly. If prolonged use is expected, students should bring in a supply from home.

Parent/Guardian Signature_____ Date _____