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 
(Please complete and return to school nurse)

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**
**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 __________