Paradise Valley Unified School District

OVER-THE-COUNTER MEDICATION PERMISSION/RECORD
(Middle/High Schools)

School Year _____ /_____

Student Name _____ **Age** _____ **Grade** _____

Teacher _____ **Drug Allergies?** ☐ **Yes** ☐ **No** **If Yes, specify:** _____

In case of minor injury or illness during the school day, I authorize the school nurse to be my agent to give my child the dosage of medication(s) listed ***based on age/weight and given in compliance with manufacturer's recommended dosage label***. I understand that alternate methods of care will be used before medication is given (i.e., eating lunch, resting, etc.).

I further understand that if my child needs other medication(s) for an extended period of time or for a chronic health condition, I must supply the medication(s) in its original pharmacy container and complete a separate medication permission form for each medication.

I agree to, and do hereby hold the district and its employees harmless from any and all claims, demands, causes of actions, liability, or loss of any sort, because of or arising out of acts or omissions with respect to this medication.

Administration of any of the following medications is at the professional discretion of the school nurse and may only be administered by the school nurse or a qualified substitute nurse.

PLEASE INITIAL NEXT TO THE MEDICATION(S) YOU ARE AUTHORIZING FOR ADMINISTRATION

Parent Initials	Medication	Parent Initials	Medication
→	Tylenol® (Acetaminophen), 80mg, 325mg, 500mg tablet(s)/suspension	→	Calamine Lotion (applied topically as needed)
→	Motrin®/Advil® (Ibuprofen), 100mg, 200mg tablet(s)/suspension	→	Caladryl Lotion (applied topically as needed
→	Benadryl® (Diphenhydramine), 12.5mg/5ml suspension - 25mg tablet(s)	→	Hydrocortisone Cream (applied topically as needed)
→	Tums® (Calcium Carbonate), 500mg (tablet(s)	→	Benzocaine (Orajel™)
→	Cough Drops		
☐ I prefer my child NOT RECEIVE any of the above medications at school.			

ISE-HS-003 ENG (Mid/High) **(Rev 04/2019)** **Signature of Parent/Guardian** _____ **Date** _____

Paradise Valley Unified School District

OVER-THE-COUNTER MEDICATION PERMISSION/RECORD
(Middle/High Schools)

School Year _____ /_____

Student Name _____ Age _____ Grade _____

Teacher _____ Drug Allergies? ☐ Yes ☐ No If Yes, specify: _____

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ISE-HS-003 ENG (Mid/High) **(Rev 04/2020)** **Signature of Parent/Guardian** _____ **Date** _____

⏭ THE FOLLOWING SECTION TO BE COMPLETED BY SCHOOL NURSE ⏮

OVER THE COUNTER MEDICATION PERMISSION/RECORD (Middle/High Schools)

Student Name _____ **Grade** _____ **Weight** _____

OTC Medication Given	Date	Time	Given By	OTC Medication Given	Date	Time	Given By

Nurse's Signature **Initials**

_____ _____

_____ _____

_____ _____

_____ _____

⏭ THE FOLLOWING SECTION TO BE COMPLETED BY SCHOOL NURSE ⏮

OVER THE COUNTER MEDICATION PERMISSION/RECORD (Middle/High Schools)

Student Name _____ **Grade** _____ **Weight** _____

OTC Medication Given	Date	Time	Given By	OTC Medication Given	Date	Time	Given By

Nurse's Signature **Initials**

_____ _____

_____ _____

_____ _____

_____ _____

ISE-HS-003 ENG (Mid/High) **(Rev 04/2020)** **Paradise Valley Unified School District**