

Student Name _____

Over-the-Counter Medication Authorization

(non-prescription medications)

Medication allergies _____

None

Other allergies/conditions that might impact medications _____

None

additional info on back of page

For simple headaches, cramps, upset stomach, sore throat, cough, tooth pain or minor injuries, a nurse or parent chaperone may administer the following over-the-counter medicines to my child:

- ANY of the medications as needed,
- NONE of the medications,
- ONLY the medications that are checked as needed

- | | |
|---|---|
| <input type="checkbox"/> Acetaminophen (Tylenol) | <input type="checkbox"/> Hydrocortisone cream |
| <input type="checkbox"/> Anbesol (for tooth pain) | <input type="checkbox"/> Ibuprofen (Advil/Motrin) |
| <input type="checkbox"/> Antacid | <input type="checkbox"/> Insect repellent |
| <input type="checkbox"/> Antibiotic ointment | <input type="checkbox"/> Insect repellent with Deet |
| <input type="checkbox"/> Benadryl | <input type="checkbox"/> Imodium |
| <input type="checkbox"/> Benadryl ointment | <input type="checkbox"/> Sore throat/cough drops |
| <input type="checkbox"/> Calamine lotion/Caladryl | <input type="checkbox"/> Sudafed |
| <input type="checkbox"/> Chigger medicine/clear nail polish | <input type="checkbox"/> Wound wash |

My child requires additional over-the-counter medications, which I will supply. I agree to also supply **specific dosing information for each non-prescription medication** when I deliver them to the Oakton High School Band Office. These medications are:

_____ additional info on back of page

Home phone _____

Cell phone _____

Business-Father _____

Business-Mother _____

THIS FORM IS FOR **NON-PRESCRIPTION** MEDICATIONS ONLY.
EACH **PRESCRIPTION** MEDICATION REQUIRES THE OFFICIAL FCPS FORM
WITH DOCTOR SIGNATURE. (included in this packet – copy as needed).

_____/_____
Parent/Guardian Signature date