North Lawrence Community Schools
Over-The-Counter Medication Consent Form

Student name:_____ **School Year:**_____

Student DOB:_____ **School:**_____ **Grade:**_____

Does your child have any allergies to medications? Yes_____ No_____
If yes, list allergy and reaction:

_____

_____

Please initial which of the following medications you would like to be provided to your student for this school year:

_____ Acetaminophen (Tylenol)

_____ Ibuprofen (Motrin)

_____ Antacid (Tums)

_____ Antihistamine (Benadryl)

*Note: Consecutive daily use of over-the-counter medications will be monitored by the school nurse and referred as needed, unless medication is otherwise ordered by the student's physician. Acetaminophen and Ibuprofen will not be used as fever-reducing medications. If a student presents with a temperature of 100 degrees or higher, parents will be notified and the student will be sent home.

I give permission for my child to receive the medications initialed above as deemed necessary by an authorized school employee in accordance with established protocols. Authorized school employees will not be held liable for damages as a result of an adverse reaction suffered by the student due to the administration of such medication. I understand that generic equivalent medications may be used in place of more expensive brand-name items.

Parent Signature_____ Date_____

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