CONSENT FORM FOR BPS APPROVED OTC MEDICATIONS

STUDENT’S NAME__________________________________________ GR ____ HR ______

Is this student allergic/sensitive to any medications? If yes, please list:

________________________________________________________________________

Please list this student’s medical/health problems:

________________________________________________________________________

Please list any long-term or daily medications your child receives:

________________________________________________________________________

I give permission for my child__________________________________________ to receive the medications checked below and deemed necessary by the School Nurse. I understand that only the School Nurse, in accordance with established written protocols, will administer these medications.

I understand that these medications may only be given once during any school day. If requested more than twice in any given week, or if a pattern of regular usage develops, I may be contacted for physician guidance or recommendations.

________________________________________________________________________

Parent/Guardian Signature Date Phone #(s)

Please CHECK the medication and CIRCLE dosage requested.

These dosage guidelines are based on patients over 12 years of age.

( ) Acetaminophen ("Tylenol"): 325mg (1 tablet)/ 650mg (2 tablets)
Orally every 4 hours as needed for ( ) menstrual cramps ( ) headache

( ) Ibuprofen ("Motrin” or “Advil”): 200mg (1 tablet) / 400mg (2 tablets)
Orally every 6 hours as needed for ( ) menstrual cramps ( ) headache

( ) Diphenhydramine ("Benadryl”): 25mg (1 tablet)/ 50 mg (2 tablets)
Orally every 6 hours as needed for itching