PERMISSION TO GIVE OTC (OVER THE COUNTER) MEDICATION

Student Name_____ Grade_____

The following medications may be given on an as needed basis after assessment by the school nurse if there are no contraindications or allergies with parent consent. Medications will be administered as directed by the manufacturer and as ordered by the school provider.

If you are able, please provide acetaminophen in the original container with your child's name on it for their use. Please have an adult bring the medication to school.

Please DRAW A LINE THROUGH any of the following medications that you DO NOT want used in the treatment of your child.

NON-ASPIRIN PAIN RELIEVER (Acetaminophen, Tylenol for pain or fever)

BENADRYL (Diphenhydramine for allergic reactions)

ANTACID (Tums for heartburn or acid indigestion)

VISINE, LUBRICATING EYE DROPS, EYE WASH, OR CONTACT SOLUTION (Minor eye irritations, Contacts)

HYDROCORTISONE CREAM 1% OR BENADRYL CREAM (Minor rashes or skin irritations)

CALADRYL CREAM OR CALAMINE (Minor skin irritations or rashes)

COUGH DROPS OR CHLORASEPTIC SPRAY (Minor throat irritation or cough)

ANBESOL OR ORAJEL (Minor mouth or tooth discomfort)

VASELINE, BLISTEX, OR CARMEX (Chapped or dry lips)

STING RELIEF SWABS OR WIPES (Insect stings or bites)

BACITRACIN OR TRIPLE ANTIBIOTIC OINTMENT (For minor cuts or wounds)

BACTINE (Cleanse minor cuts and wounds)

I authorize the use of the above medications for my child. Authorization is in effect for the 2025-2026 school year.

Parent/Guardian Signature_____

Date_____

(COMPLETE BOTH SIDES)

Smethport Area School District
Medical Information and Authorization for School Health Services

The following information is needed in order for the school nurse to give the most effective medical attention and treatment of your child. Please complete and return this form.

Student's name: _____ Date of Birth: _____Grade: _____

Medical conditions, mental/emotional conditions, and/or physical limitations:
_____
_____

Surgical history (any past surgeries):_____
Does your child have a severe allergy? (Food, insect sting, medication, other) Please specify:
_____
What treatment is necessary? _____

Does your child require an Epi-pen or rescue inhaler during school? YES NO (please circle one)

Does your child wear glasses or contacts? YES NO (please circle one)

List any daily medications taken; please give name, dose, and frequency:
_____
_____

Please provide a copy for your child's immunization record, **ONLY IF NEW IMMUNIZATIONS** have been given in the past year.

In the case of an extreme emergency, and we are unable to contact you, your child will be transported to a nearby hospital. Please indicate hospital preference.
_____

Physician's name: _____
Phone: _____ Date of last visit: _____
Dentist's name: _____
Phone: _____ Date of last visit: _____

I give my permission to make the information on this form available to authorized school and transportation personnel if necessary. I also give permission to my child's health care provider/dentist to share any necessary information relating to my child's health with the school nurse.

Parent/Guardian Name Printed: _____Phone:_____

Signature: _____Date:_____

(COMPLETE BOTH SIDES)