

**OVER THE COUNTER MEDICATION PERMISSION SLIP**

**STUDENT NAME:** \_\_\_\_\_

**STUDENT DATE OF BIRTH:** \_\_\_\_\_

I give the Winston School designated staff member permission to administer the following over-the-counter medications, should the need arise, while the student is at school. I further certify that, to the best of my knowledge, my child is not allergic to any of the approved over-the-counter medications. Dosages will be administered according to the directions on the label.

**Please cross off any medications that are NOT approved and sign below:**

Pill and Chewable

Headache	Tylenol (acetaminophen) or Motrin (ibuprofen)
Muscle Pain:	Motrin (ibuprofen)
Upset Stomach:	Pepto Bismol, Tums (calcium carbonate). Maalox (magnesium hydroxide and aluminum hydroxide)
Diarrhea	Immodium AD
Bee/Wasp Sting	Benadryl
Allergy	Benadryl

Topical

Cuts	Bacitracin antibiotic ointment
Poison Ivy:	Calamine lotion; Benadryl cream or Cortaid cream
Bites and itches	Calamine lotion, Benadryl cream or Cortaid cream

These items are in the main office. If you have a specific over the counter medication that you would like your child to have, please feel free to send the medication in and have it labeled with your child's name.

Print Student's Name: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_

Parent/Guardian phone number \_\_\_\_\_

Dated: \_\_\_\_\_