THE WINSTON SCHOOL
OF SHORT HILLS

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: _____