OVER THE COUNTER MEDICATION PERMISSION FORM

School Year: 2023-24

School District of Marshfield
Nursing/Health Services

STUDENT NAME:_____ GRADE: _____ SCHOOL: _____

Our schools stock commonly requested over the Counter (OTC) medications for as needed use. For schools in Wisconsin, OTC medication taken as directed does not require a physician's prescription, however, **written consent is required before ANY medication is given to students under the age of 18.**

Please check YES for any of the medications that you would like your child to receive (per recommended dosing and as directed on the label) in the event of a minor illness or injury.

YES	ORAL	REASON
	Acetaminophen (Tylenol)	Headaches, Musculoskeletal pain Menstrual cramps
	Ibuprofen (Advil)	
	Calcium Carbonate (Tums)	Antacid, Indigestion 12 years old and up
	Calcium Carbonate, Aluminum, Magnesium (Pepto Kids)	Antacid, Indigestion 5 to 11 years old
	Lozenges (Menthol)	Cough, sore throat 5 years old and up

YES	TOPICAL	REASON
	Bacitracin	Moisturize to limit scars Reduce risk of infection Ease pain
	Triple antibiotic ointment (Neosporin)	
	Burn Gel	Cools and soothes superficial burn
	Hydrocortisone 1%	Soothes Itch, skin rash and redness
	Medicated lip ointment (Blistex)	Alleviates cracked and seriously chapped lips
	Sting Relief (Benzocaine, Lidocaine, Menthol)	Itch, sting relief for bug bites and stings
	Calamine Lotion	Relieves itchy skin, rash, and bug bites

By initialing and signing below a parent or legal guardian acknowledges:

Initial Here: _____ The student has no known allergies or sensitivities to any of the checked oral or topical medications.

Initial Here: _____ The school health room may limit the frequency of use or require families to provide a personal supply of medication after 5 or more doses have been administered during a school year.

*****Please choose either of the following*****

Initial Here: _____ The school health room **will not** contact you each time any of the checked medications are administered, unless determined to be more than a minor illness or injury.

Initial Here: _____ The school health room **will** contact you each time any of the checked medications are administered.

Signature of Parent/Legal Guardian: _____ Date: _____

*For OTC medication not listed on this form, or if the medication must be given on a regular basis, please use the forms Medication Permission and Instruction or Student Self Medication Request. *