



Authorization for Administration of Over-the-Counter Medications at School

This form expires at the end of the current school year.

Student Name _____
School Year

School Grade _____
Homeroom

As this student's parent/guardian, I give permission for my child to receive the following medications during school hours or during after-school activities. (Circle yes or no to all that apply.) Also, please mark if your child is allergic to any of these medications.

Over-the-Counter Medication	Circle those that apply		
Acetaminophen (Tylenol) for headache	Yes	No	Allergic
Acetaminophen (Tylenol) for toothache or minor pain	Yes	No	Allergic
Ibuprofen for menstrual cramps	Yes	No	Allergic
Ibuprofen for headache, toothache or minor pain	Yes	No	Allergic
Anti-itch cream or lotion	Yes	No	Allergic
Cough drops	Yes	No	Allergic
Tums (antacid)	Yes	No	Allergic

I give permission to the Cincinnati Health Department school nurse or Cincinnati Public School designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless the Cincinnati Health Department or Cincinnati Public Schools and its agents from all claims as a result of any and all acts performed under this authority.

Signature of Parent/Guardian _____
Date

Parent/Guardian Name (Please Print)

How can we reach you during school hours?

Work Phone Home Phone Cell Phone Pager _____
Other

NOTE: If your child has a chronic medical condition such as diabetes, severe allergies, migraines, or sickle cell anemia, please have your child's physician complete and sign an individual medication consent form obtained from the school nurse or school office.