**Region 10 Technical High School**
**68 Church Road**
**Brunswick, Maine 04011**
Phone (207) 729-6622 Fax (207) 721-0907

# OVER THE COUNTER MEDICATION CONSENT FORM

Student's Name_____ School Year_____

Dear Parent/Guardian:
Region 10 Technical High School has standing orders from our health advisor, Dr. Alyssa Goodwin, to administer the following non-prescription medications for our students, with parent/guardian permission and administer according to manufacturer's recommendations:

- Tylenol or acetaminophen 500 mg-take 2 tablets po every 6 hours as needed for pain. Do not exceed 6 tablets in 24 hours.
- Motrin or ibuprofen 200 mg- take 1 or 2 tablet(s) po every 4-6 hours as needed for pain. Do not exceed 6 tablets in 24 hours.
- TUMS or a generic brand for indigestion- 2-4 tablets po as symptoms occur. Do not exceed 15 tablets in 24 hours.
- Caladryl lotion or a generic brand- apply to affected areas 3-4 times daily.
- Solarcaine spray or generic brand- apply a thin layer to affected areas 2-3 times daily.
- Antibiotic ointment for first aid- apply to affected areas 1-3 times daily.
- Benadryl Allergy or diphenhydramine 25 mg tablet for allergic reactions- take 1 or 2 tablets every 4-6 hours as needed. Do not exceed 6 tablets in 24 hours.

Parent/Guardian written permission is required to administer any of the above listed non-prescription medications.

**Return this signed permission form to the main office**

I, _____ give the school nurse or his/her designee permission to administer to my child _____ the above non-prescription medications as needed, according to the manufacturer's recommendations.

This signed permission slip is a permanent authorization for your child while enrolled in this school district for the current school year. If at any time you wish to discontinue your child's non-prescription medication, please notify the school.

Does your child have any allergies to medications? Yes_____ No_____

If yes, please list what medication and the reaction:
_____

Note: If a child demonstrates habitual usage of over-the-counter medications, a doctor's order may be requested to verify that ongoing symptoms have been evaluated and you will need to provide the medication.

Signature_____ Date_____

Printed Name_____