LABBB Health Office at Lexington High School
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OVER THE COUNTER (OTC) MEDICATION PERMISSION FOR ELEMENTARY AND MIDDLE SCHOOL STUDENTS

Student name: _____ DOB: _____ Allergies:_____

Over the Counter Medications (available at school program):
I authorize my student to receive the following medications in school if needed, per LABBB Standing Orders and medication administration protocol (check all that apply):

- ☐ **Acetaminophen (oral):**
  Children's Acetaminophen *Dye-Free* Liquid (160 mg/5 mL)
- ☐ **Ibuprofen (oral):**
  Children's Motrin *Dye-Free* Liquid (100 mg/5 mL)
- ☐ **Tums (oral):**
  Calcium Antacid Chewable (500 mg/tab)
- ☐ **Bacitracin (topical):**
  Bacitracin Zinc Antibiotic Ointment

Oral over-the-counter medication doses are calculated based on weight for children under the age of 12. Current weights must be provided for nurses to administer over-the-counter medications to students under 12.

Student's current weight: _____ lbs

**** If your child will need any of the above medications in formulations that are not supplied by the school, please have your child's pediatrician complete the LABBB Prescription Medication Order form.****

My student is currently taking the following medications (to be completed if not in violation of confidentiality):
_____
_____

Parent/Guardian Authorization for Medication Administration:
I, the undersigned, give permission to the school nurse to administer the above medication(s).

Parent/Guardian signature: _____ Date: _____

Parent/Guardian telephone (cell and work): _____

LABBB Nurse signature: _____ Date: _____