Owensboro Catholic Schools
Consent for Non-Prescription Medications Provided by the School
*(As Approved for **2011-12** Academic Year)*

Student's Name_____ **Age** _____ **Birthday**____/____/____ **Grade** _____
(Last) (First) (MI)

The following medications may be available at your child's school. By placing an **"X"** in the box beside the medication(s) listed below, you are giving your consent for your child to receive the specified non-prescription/over-the-counter medication(s) on an "as needed" basis during the 2011-12 academic year. Your consent authorizes the appropriate medication administration staff to administer to your child, any of the marked non-prescription/over-the-counter medication(s), in accordance with the manufacturer and pediatric guidelines, as indicated by signs, symptoms, &/or complaints that your child may have. Parent/guardian will be contacted if temperature is ≥100.4, if complaint continues, or if complaint increases after intervention.

NO (X)	YES (X)	I give my consent for my child to receive the following symptom-specific over-the-counter-medications if needed as marked "Yes:"
○	○	**Advil or generic equivalent ibuprofen** • **5 to 10 years old:** weight based to 100 pounds or 10 years old, every 6 hours as needed for headache, minor aches, pain • **≥ 10 years old and/or ≥ 100 pounds,** 200 mg 1 to 2 tablets every 6 hours as needed for headache, minor aches, pain • **≥ 12 years old or ≥ 120 pounds:** 200 mg 1 to 2 tablets every 6 hours as needed for headache, minor aches, pain
○	○	**Tylenol or generic equivalent acetaminophen** • **5 to 10 years old**: Weight based to 100 pounds or 10 years old, every 4 hours as needed for headache, minor aches, pain • **≥ 10 years old and/or ≥ 100 pounds:** 650 mg every 4 hours as needed for headache, minor aches, pain • **≥ 12 years old or ≥ 120 pounds:** 500-1000 mg every 4 hours as needed for headache, minor aches, pain
○	○	**Tums or equivalent generic antacid with calcium carbonate** 1or 2 chewable tablets every 4 hours as needed for nausea, upset stomach
○	○	**Caladryl or generic equivalent** topical lotion every 4 hours as needed for skin irritations, itching
○	○	**Carmex Lip Balm or generic equivalent** apply sparingly every 2 to 4 hours as needed for cold sores
○	○	**Chapstick, Blistex Lip Balm, or generic equivalent** every 4 Hours as needed for chapped lips/lip irritation
○	○	**Chloraseptic Lozenge or generic equivalent with phenol** 1 every 2 hours as needed for sore throat pain
○	○	**Cough Drop: Halls or generic equivalent cough drop**1 lozenge every 2 hours as needed for cough or throat irritation
○	○	**Dermaplast Spray** every 2 hours as needed for itching, minor burns, or insect bites
○	○	**Eye Drops: Allergy Relief/Lubricating** 1 or 2 drops every 2 to 4 hours as needed for eye irritation
○	○	**Eye Drops: Rewetting** 1 or 2 drops every 2 to 4 hours as needed for contact lens discomfort or eye irritation
○	○	**Hydrocortisone Topical Cream 1% or generic equivalent** every 4 hours as needed for skin irritations, itching
○	○	**Hydrogen Peroxide** (½ Strength) 2 times/day as needed for wound cleansing, use for 1 to2 days only
○	○	**Lotion: Vaseline Intensive Care or generic equivalent** topical every 4 hours as needed for chapped or irritated skin
○	○	**Oragel or generic equivalent** every 1 hour as needed for minor mouth pain
○	○	**Polysporin or generic equivalent antibiotic ointment** 4 times a day as needed for minor cuts, abrasions
○	○	**Sterile Saline Solution** as needed for contact lens care
○	○	**Vaseline Petroleum Jelly or generic equivalent** topical every 4 Hours as needed for lip or minor skin irritation
○	○	**FOR URGENT/ACUTE USE ONLY:** **Benadryl or generic equivalent diphenhydramine liquid (12.5 mg per 1 teaspoon)** • Children 6to 12 yrs (48-95 pounds) 1 or 2 teaspoons every 4 hours as needed for hypersensitivity reaction symptoms as per OCS Hypersensitivity Reaction Protocol • Children ≥12 yrs (≥96 pounds) 2 or 4 teaspoons every 4 hours as needed for hypersensitivity reaction symptoms as per OCS Hypersensitivity Reaction Protocol

LIABILITY RELEASE: In case of medical or surgical emergency, I/we hereby request and give permission to the staff at Owensboro Catholic Schools for the hospitalization and/or provision of necessary medical treatment for the above-named child. I/We understand that depending upon the seriousness of the above named child's situation/injury, 911 may be contacted & he/she may be transported to the nearest hospital. I/We understand that I/we will be responsible for the cost of any medical treatment incurred (including surgery) to treat my child. I/We understand that I/we will be contacted immediately in the case of an emergency to my child. I/We understand that if there are any changes to the any information (i.e. contact information, insurance policy, medical conditions, medications, court orders, etc.), that it is my responsibility to keep my child's school records updated and will report any changes to my child's School Office at once. I hereby agree to the terms listed on this document and release and hold the medication administration staff in the Owensboro Catholic Consolidated Schools and OMHS staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from administration of the medications listed above that I have marked "YES."

_____ _____
Parent/Guardian Signature **Date**

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