**Owensboro Catholic Schools**

# Consent for Non-Prescription Medications Provided by the School

**School Year: 20Choose an item. - 20 Choose an item.**

**Student's Name_____ Age Choose an item.**

**(Last) (First) (MI)**

**Birthday____/____/____ Grade Choose an item.**

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 above listed 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**<br>• **5 to 10 years old:** weight based to 100 pounds or 10 years old, every 6 hours as needed for headache, minor aches, pain<br>• **≥ 10 years old and/or ≥ 100 pounds,** 200 mg 1 to 2 tablets every 6 hours as needed for headache, minor aches, pain |
| ☐ | ☐ | **Tylenol or generic equivalent acetaminophen**<br>• **5-10 years old:** weight based (10 mg/kg) to 100 pounds or 10 years old every 4 hours as needed for headache, minor aches, pain<br>• **≥10 years old and/or ≥100 pounds:** 500 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 |
| ☐ | ☐ | **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 Serious Acute Hypersensitivity Reaction Only (per OCS protocol):**<br>**Benadryl or generic equivalent diphenhydramine liquid (12.5 mg per 1 teaspoon OR 12.5 mg per 1 quick-melt tablet)**<br>• Children 6 to 12 yrs (48-95 pounds) 1 or 2 teaspoons OR 1 or 2 quick-melt tablets every 4 hours as needed for hypersensitivity reaction symptoms as per OCS Hypersensitivity Reaction Protocol<br>• Children ≥12 yrs (≥96 pounds) 2 or 4 teaspoons OR 2 or 4 quick-melt tablets every 4 hours as needed for hypersensitivity reaction symptoms |
| ☐ | ☐ | **For Serious Acute Hypersensitivity Reaction Only (per OCS protocol):**<br>**School-Stock Epinephrine By Auto-Injector per House Bill 172**<br>• Child weighing approximately ≤ 66 pounds, auto injector 0.15 mg Injection immediately to outer thigh if needed for severe hypersensitivity/anaphylactic reaction symptoms<br>• Child weighing approximately ≥ 66 pounds thru adult, auto injector 0.3 mg Inject immediately to outer thigh if needed for severe hypersensitivity/anaphylactic reaction symptoms. If weight unknown, use epinephrine by auto injector 0.3 mg dose |

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 Owensboro Health 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 Name **(Signature)**

☐ Please check this box if you understand that by typing your name, it is the same as your signature.

_____ Date