**Student Name:_________________________________DOB:_____________Grade:_________**

## PART IV: CONSENT FOR MEDICATION

### Consent for Over the Counter (OTC) Medications

Check (√) the over-the-counter medications that you permit us to administer to your daughter in school. The ***appropriate dose*** will be administered as indicated unless otherwise specified by the physician/nurse practitioner.
**All medications, both over-the-counter and prescribed, must be re-ordered by the provider and authorized by the parent *EVERY SCHOOL YEAR*.**

____Advil, Motrin (Ibuprofen) 400 mg every 6 hours.

____Antacid tablet 1-2 tablets every 8 hours.

____Antibiotic Ointment

____Benadryl (Diphenhydramine) 25 mg every 4-6 hours

____Hydrocortisone Cream 1%

____Tylenol (Acetaminophen) 500 mg every 4 hours.

Parent/Guardian Signature _________________________________Date_____________

Physician/Nurse Practitioner Signature ________________________Date_____________

Printed Name_________________________________ Phone______________________

***This form must be signed by both Parent AND Physician/NP to be valid.**

□ I hereby give permission for my daughter to receive medications as indicated above and/or as deemed necessary by the school nurse or designated personnel in accordance with established protocols.

□ I **DO NOT** want any medication given to my daughter in school.

**PART IV: Consent for Prescription Medications:**
Please use the Mount de Sales Academy Medication Administration Form for all prescription medications. **All medications, both over-the-counter and prescribed, must be re-ordered by the provider and authorized by the parent *EVERY SCHOOL YEAR*.**