PCA

ORDER FOR OVER-THE-COUNTER MEDICATION

Student's Name: _____ Date of Birth: ___/____/_____

I give permission for the school nurse, or the principal's designee, to administer to my child the following over-the-counter medications, as appropriate:

	Yes	No
Motrin/Advil (Ibuprofen)	☐	☐
Tylenol (Acetaminophen)	☐	☐
Benadryl	☐	☐

Any other over-the-counter medication should be brought in to PCA by the parents with specific instructions for use (i.e cough drops, Aleve, Lactaid, etc).

_____
Parent/Guardian's Name

_____ _____
Parent/Guardian's Signature Date

Allergies: (to medications, foods, insects, latex, other):

_____

_____

********** I give permission to the PCA nurse, or the principal's designee, to administer epinephrine in the event that my child experiences a severe, life-threatening, anaphylactic allergic reaction at school. I understand that in the event of this occurrence an ambulance will be summoned and emergency treatment will be given to my child.

_____ _____
Parent/Guardian's Signature Date