ROCKBRIDGE
ACADEMY

Permission to Administer OVER-THE-COUNTER Medication

Student Last Name_____Student First Name_____DOB_____Grade_____

Allergies_____Weight_____Services ☐ Beginning to end of school year

Type of Medication	**Description of Symptoms**	**Dosage for this mediation as approved by physician.**
Acetaminophen	Headache, muscle aches, pain, menstrual cramps, fever	Dosage_____ Frequency_____
Ibuprofen	Headache, muscle aches, pain, menstrual cramps, fever	Dosage_____ Frequency_____
Topical pain/itch relief:	Rash, inflammation, insect bites, itch	Dosage_____ Frequency_____
Diphenhydramine (Allergy/Benadryl)	Runny nose, sneezing, itchy/watery eyes/itching of nose/throat	Dosage_____ Frequency_____
Other: _____	_____ _____	Dosage_____ Frequency_____

- ✓ All OTC medication will have a physician's signed order fully completed for each school year.
- ✓ The OTC medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label.
- ✓ The medication will be brought to school by an adult.
- ✓ The physician will be called if a question arises about my child's medication.
- ✓ The first dose of this medication has been given without any negative side effects.
- ✓ You agree on behalf of yourself and your child/ward to indemnify and hold harmless Rockbridge Academy, it's employees and servants for any claim to damages, compensation or otherwise and to reimburse or make good any loss or damages or costs that they may have to pay if any litigation arises on account for any claims made by said minor or anyone on his/her behalf.

PHYSICIAN Signature:_____

Physician Name Printed:_____

School Year:_____Today's date:_____

Address/Office Stamp:

_____

HEALTH ROOM USE ONLY

Form RECEIVED date_____
By (signature)_____
Form REVIEWED date_____
By (signature)_____

Having read the above conditions, I request that the RA Health Aide administer the OTC medication to my child. I certify that I have legal authority to consent to medical treatment for the student named above including the administration of medication at school.

PARENT/Guardian
Signature:_____

Relationship to Student:_____

Phone: _____Email:_____

Address:_____

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