United Local School Health Services
8143 State Route 9
Hanoverton, Ohio 44423

Nurse's Phone: 330-223-2829 Fax: 330-223-2363

Student
Grade_____

Teacher_____

PARENTAL PERMISSION FOR OVER THE COUNTER MEDICATION

Student Name: _____ Date of Birth:_____

Emergency Telephone Contact Number:_____

The school nurse has a limited supply of over the counter medication that may be dispensed with written parental permission. Students requesting medication must be evaluated by the school nurse and may receive medication for minor muscle aches and pains or discomfort due to the common cold, headache, toothache or menstrual cramps. The school nurse may contact you to discuss the frequency of your child's request for medication, or to recommend follow up care with your health care provider. This form must be completed in full each school year by a parent or guardian. All other over the counter medications must be approved by the nurse and supplied by the parent or guardian before use.

Check off each medicine that you give permission for your child to receive, and CROSS OUT any that should not be given.

- □ acetaminophen (generic Tylenol) per label directions
- □ ibuprofen (generic Advil) per label directions
- □ anti-itch creams and lotions (hydrocortisone/generic calamine)
- □ antibiotic ointments for minor cuts and scrapes
- □ Orageł/Ambesol
- □ antacids (Tums, Pepto Bismol)
- □ cough drops/ chloroseptic spray
- □ other _____

I give permission for the school nurse, a substitute nurse, or any other member of the school staff designated by the principal, to administer the medications that are checked off above. By signing this form, I agree to hold harmless and indemnify the United Local School District and any staff member for any and all losses that may be occasioned as a result of taking this medication, including adverse reactions. **I understand that the use of ibuprofen or acetaminophen is limited to two doses in one month and a doctor's evaluation and medications order will be required if my child needs to take analgesics more frequently.**

HEALTH HISTORY (This history form must be filled out in full each school year)

Does your child wear: ☐ Glasses ☐ Contacts

Date of your child's last complete physical _____ Practitioner: _____

List any serious food, drug or other allergies _____

What reaction does the allergy cause? _____ Uses EpiPen or Benadryl ☐ yes ☐ no

Is your child currently being treated for asthma? ☐ yes ☐ no Uses inhaler/nebulizer ☐ Daily ☐ Often ☐ Never

Does your child have any diagnosis/conditions that may affect routine care? ☐ yes ☐ no
If yes, explain_____

Routine medications taken at home: _____

Has your child had any hospitalizations or broken bones in the past year? ☐yes ☐no
If yes, if explain_____

Do you give permission for the above health information to be shared with your child's classroom teachers? ☐ yes ☐ no

Date _____ **Parent/Guardian's Signature** _____