HORIZONS®
The Harley School

Permission to Administer Over-the-Counter & Prescription Medications

Valid for all program-sponsored activities

Student Name _____ DOB _____ Age _____ Grade _____

Medication Allergies _____

Permission to Administer Over-the-Counter (OTC) Preparations

Check the items your child may have/use. Cross out the items your child may not have/use.

- ☐ Vaseline Petroleum Jelly or Aquaphor for chapped skin or lips
- ☐ Aloe gel or cream for a minor skin irritation
- ☐ Unscented hand/body moisturizing lotion
- ☐ Calamine lotion/Benadryl for an itchy rash or insect bite
- ☐ Ophthalmic saline for contact lenses
- ☐ Eye drops for allergy/eye irritation
- ☐ Bactine spray/isopropyl alcohol/hydrogen peroxide as antiseptic
- ☐ Bacitracin ointment for a minor skin wound/abrasion
- ☐ Burn spray/gel/ointment for minor burns
- ☐ Sunscreen to prevent sunburn (supplied from home)
- ☐ Insect repellent (supplied from home)
- ☐ Tums for indigestion
- ☐ Cough drops for sore throat/cough in a child with a good cough and swallow reflex
- ☐ Bonine or Dramamine for motion sickness (supplied from home)
- ☐ Acetaminophen – 325 mg. or 160 mg. per tsp. (dose per age/weight)
- ☐ Ibuprofen – 200 mg. tab or 100 mg. per tsp. (dose per age/weight)
- ☐ Benadryl – 25 mg. tab or 12.5 mg. per tsp. (1-2 tsp. or 1-2 tabs every 6 hours for allergic reaction)

OTHER _____

Prescription Medications

Please list all prescription medications and dosages to be administered during the school day:

1_____ ☐ School and/or ☐ Field trip

2_____ ☐ School and/or ☐ Field trip

3_____ ☐ School and/or ☐ Field trip

4_____ ☐ School and/or ☐ Field trip

PHYSICIAN, please check if applicable and sign below:

☐ If morning dose is not given at home, Nurse may administer morning dose of _____, with verbal or written notice from parent.

☐ I assess this child to be **self-directed**, and ☐ may **self-carry** medication.

Parent and Physician Signatures

I give permission for my child/patient to use the over-the-counter preparations and prescription medications listed above. I have crossed out the items he or she may not have/use. Administration of over-the-counter medications will be "per label" directions for age/weight, unless otherwise indicated by provider.

_____ _____ _____
Parent Signature (required) Daytime Phone Date

_____ _____
Physician Name (please print) Office Phone

_____ _____
Physician Signature (required) Date