Cincinnati Public Schools

Authorization for Administration of Over-the-Counter Medications at School

This form expires at the end of the current school year.

Student's Name	Date of Birth	School Year

Street Address	Apt. No.	City	State	Zip

School	Grade	Homeroom

As this student's parent/guardian, I give permission for my child to receive the following over-the-counter medications during school hours or during after-school activities. I agree to provide the medication my child needs in the original labeled container with the protective seal intact.

(Circle yes or no for each medication listed below. Physician to complete dosage and time/frequency)

Over-the-Counter Medication (Parent to Complete)	**Circle**		**Dosage (Physician to complete)**	**Time/Frequency (Physician to complete)**
Acetaminophen (Tylenol) for headache, toothache or minor pain	Yes	No		
Ibuprofen for headache, toothache, minor pain or menstrual cramps	Yes	No		
Anti-itch cream or lotion	Yes	No		
Cough drops	Yes	No		
Tums (antacid)	Yes	No		

Is student allergic to any medications? ☐ No ☐ Yes, allergic to _____

Severe reactions that should be reported to the physician: _____

Student's Provider (Physician/Nurse Practitioner/Dentist) **Complete dosage and frequency above

Provider's Signature: _____ Date: _____

Provider's Name: _____ Emergency Phone #: _____

I give permission to the Cincinnati Health Department school nurse or Cincinnati Public Schools' designee to give my child the above-mentioned medications for comfort measures. I further agree to indemnify or hold harmless the Cincinnati Health Department or Cincinnati Public Schools and its agents from all claims as a result of any and all acts performed under this authority. I will inform the school if there is a change in any of this information.

Signature of Parent/Guardian	Date

Please Print Name of Parent/Guardian

How can we reach you during school hours?

Work Phone	Home Phone	Cell Phone	Pager	Other

Cincinnati Public Schools

Over-the-Counter Medication Record 2015-16

FOR OFFICE USE ONLY. Use one form per Over-the-Counter Medication.

Student's Name: _____ Weight: _____ Date of weight_____

Medication: _____ Dosage:_____ Route:_____ Frequency:_____

(No Students days are gray on this calendar.)

AUGUST 2015				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28
31				

SEPTEMBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30		

OCTOBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30

NOVEMBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30				

DECEMBER				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30	31	

JANUARY 2016				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

FEBRUARY 2016				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29				

MARCH				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30	31	

APRIL				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

MAY				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30	31			

JUNE				
Mon	*Tues*	*Wed*	*Thurs*	*Fri*
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	

Signatures:

_____ Initials _____

_____ Initials _____

Signatures:

_____ Initials _____

_____ Initials _____