VAN ALSTYNE ISD

Stock Medication Permission Form

Student's Name _____ DOB _____

Grade _____ Student Allergies _____

Check yes or no to indicate which of the approved list of over-the-counter medications/treatments may be administered by the school nurse or trained staff when indicated by student's symptoms.

Over-the-Counter Medication	Dosage and Time	Condition/Symptoms
Acetaminophen (Tylenol ®) (*For high school and middle school only)* ☐ Yes ☐ No	Administer according to the manufacturer's label	For relief of minor aches and pain; fever will not be treated at school
Ibuprofen (Advil ®, Motrin ®) (*For high school and middle school only)* ☐ Yes ☐ No	Administer according to the manufacturer's label	For relief of body aches and pain or menstrual cramps; fever will not be treated at school
Diphenhydramine (Benadryl ®) ***(For emergent use only)*** ☐ Yes ☐ No	Administer according to the manufacturer's label	For allergy symptoms (hives/itching)
Generic cough drops (*For high school and middle school only)* ☐ Yes ☐ No	Administer according to the manufacturer's label	For coughing
Calamine lotion ☐ Yes ☐ No	Apply to skin according to the manufacturer's label	For poison ivy/bug bites
Neosporin ☐ Yes ☐ No	Apply to skin according to the manufacturer's label	To help prevent infection and for temporary relief of pain or discomfort in minor cuts, scrapes, or burns
Aloe Vera ☐ Yes ☐ No	Apply to skin according to the manufacturer's label	For temporary relief of pain and itching associated with minor cuts and burns
Hydrogen Peroxide or Alcohol ☐ Yes ☐ No	Apply according to the manufacturer's label	To help prevent risk of infection in minor cuts, scrapes, and burns
Refresh Eye Drops ☐ Yes ☐ No	Administer according to the manufacturer's label	To relieve dryness of the eye and prevent further irritation of the eye
Vaseline ☐ Yes ☐ No	Apply according to manufacturer's label	For chapped lips and to protect chafed skin
Hydrocortisone Cream ☐ Yes ☐ No	Apply to skin according to manufacturer's label	For the temporary relief of itching associated with minor skin irritations, inflammation, and rashes

I request the designated school personnel to assist my child in the administration of the above described medication/s. I understand that there is no liability on the part of the school district, its personnel, or agents, for civil damages as a result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances. I understand these medications are stocked and maintained by the school clinic with standing orders prescribed by the overseeing physician.

Parent/Guardian Signature _____ Date _____