CONSENT FOR NON-PRESCRIPTION MEDICATIONS

I give my permission for my child,_____, Grade_____, to receive non-prescription medication at school if necessary to relieve minor pain and discomfort.

Signature of Parent/Guardian_____, Date_____.
Please mark each medication/generic equivalent your child may receive at school. Dosage will be age appropriate as per manufacturer's directions. Generic equivalent medication may be substituted for brand name. NOTE: Any medication taken routinely at school will need a separate medication form filled out by a doctor.

MEDICATION	YES	NO
Pain Relievers		
Tylenol/Acetaminophen		
Advil/Ibuprofen		
Antacids		
Tums		
Pepto Bismol		
Cough Drops/Syrup		
Cough Drop		
Cough Syrup		
Sinus Medication		
Sudafed (non drowsy)		
Benadryl/Diphenhydramine 25 mg.		
Topical/First Aid Creams		
Caladryl		
Neosporin		
Peroxide		
Alcohol		
Hydracortisone		
Sports Cream/Muscle Rub		
Aloe Vera		
Chapped Lips/Skin		
Vaseline		
Lip Balm		
Eye Drops		
Artificial Tears		
Contact Solution		
Sterile Eye Wash		
Visine		
Cold Sore/Fever Blister		
Campho-phenique		
Orabase/Oragel		
Anti-Diarrhea		
Imodium		

RCS YEAR 2021 – 2022