School for the Deaf and the Blind Engage • Empower • Equip	**Permission for School Administration of SCSDB stock or OTC medication sent fromhome.** **Over-the-counter Medications (OTC)** CSA Health Center 864-577-7780Fax 864-577-7629	**B**

When possible, medications should be given to students before or after school by the parent or guardian. Over the counter medications (OTC) may only be given within the limits and according to the instructions printed on the container or the package insert. The school district may reject requests for certain medications to be given at school.

Note: Nursing staff will not administer any OTC alternative medications, including herbal supplements or essential oils, with or without a physician's order.

*Child's Name _____ Date of Birth _____

Is your child allergic to any food, medicines, or other items?
□ No
□ Yes (If yes, list allergies):

Over the Counter medications provided by SCSDB are in generic form:

Acetaminophen	Betadine Solution	Hydrogen Peroxide
Antacid	Bismuth subsalicylate	Ibuprofen
Anti-emetic	Calcium Carbonate	Laxative
Antibiotic Ointments	Camphor-phenol topical	Nose spray
Antidiarrheal	Cough & cold medications	Pseudoephedrine
Antihistamines	Dextrose	Saline nasal spray
Benzocaine topical	Hydrocortisone	Throat spray

Does your child take any other medications at home?
□ No
□ Yes (If yes, what are the medications?)

*Over-the-counter medication from home:	Dose:
	Frequency:

I give permission for the medication noted above to be given to my child during the school day if needed. I understand that the school may require that I agree to the school district's rules about medications before this medicine will be given at school. I will not hold the school, school district or school personnel liable for any adverse drug reactions when the medication is administered according to the instructions on the label or package insert. I understand that I am responsible for notifying the school if any of my child's medications change and/or if my child's health status changes.

* _____ * _____
Signature of Parent / Guardian Date

* _____ * _____
Print or Type Name of Parent / Guardian Day Phone Number

*All areas with asterisks must be completed.