Permission for School Administration of SCSDB stock or OTC medication sent from home.

Over-the-counter Medications (OTC)

CSA Health Center 864-577-7780
Fax 864-577-7629

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.

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:

<table>
<thead>
<tr>
<th>Acetaminophen</th>
<th>Betadine Solution</th>
<th>Hydrogen Peroxide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antacid</td>
<td>Bismuth subsalicylate</td>
<td>Ibuprofen</td>
</tr>
<tr>
<td>Anti-emetic</td>
<td>Calcium Carbonate</td>
<td>Laxative</td>
</tr>
<tr>
<td>Antibiotic Ointments</td>
<td>Camphor-phenol topical</td>
<td>Nose spray</td>
</tr>
<tr>
<td>Antidiarrheal</td>
<td>Cough &amp; cold medications</td>
<td>Pseudoephedrine</td>
</tr>
<tr>
<td>Antihistamines</td>
<td>Dextrose</td>
<td>Saline nasal spray</td>
</tr>
<tr>
<td>Benzocaine topical</td>
<td>Hydrocortisone</td>
<td>Throat spray</td>
</tr>
</tbody>
</table>

Does your child take any other medications at home?

☐ No
☐ Yes (If yes, what are the medications?)

*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.