ACADEMY OF THE HOLY FAMILY

54 West Main Street * Baltic, Connecticut 06330 * Telephone: (860) 822-9272 * Fax: (860) 822-1318
Health Aide: Mrs. Patricia C. Penney * E-Mail: ppenney_health@ahfbaltic.org

AUTHORIZATION FOR OVER-THE-COUNTER (OTC) MEDICATION FORM BY SCHOOL PERSONNEL YEAR: 20____ - 20____

THIS FORM MUST BE RENEWED ANNUALLY AS PER ACADEMY OF THE HOLY FAMILY SCHOOL GUIDELINES

Student Name (Last, First, MI): _____ **Date of Birth:** ____/____/____ **Grade:** ____

Medication Allergies: _____ Describe reaction: _____

_____

Beginning the ***2016 – 2017*** School Year, the administering of "stock" Over-the-Counter (OTC) medications in our school setting will change. These are medications purchasable without a prescription that we supplied to students as needed and kept in the school Health Office.

RESIDENTIAL STUDENTS ONLY

Please read the Self-Administration of Over-the-Counter Medications information in the Student Handbook.
Parent/Guardians **MUST** supply their student with a small bottle of over-the-counter medications and give consent in writing below **before** any OTC medication will be given.
All medications and nutritional supplements brought to campus must be registered in the school Health Office.
The School Health Aide determines where the items will be stored.

ALL STUDENTS

***Nonprescription medication will only be dispensed per package directions. Doses outside the range listed on the label of the medication will only be given if we have written and signed authorization by your student's licensed health care provider and you.**
***Aspirin containing products will not be administered without written and signed authorization from parent/guardian and your students' licensed health care provider due to safety reasons.**

Below is the list of OTC medications that will be kept in the school Health Office for the school year 2016-2017. If a student requires any of the below medication(s) on a regular basis, parent/guardian **must** provide the medication in its original labeled unopened container.

Please check "Yes" or "No" to allow your child to take OTC medication.

Over-the-Counter Medication dispensed per package directions:	Indications:	Yes / No
Acetaminophen (Tylenol type Generic) Tablet ☐ 325 mg ☐ 500 mg	Pain Reliever / Fever Reducer	☐ Yes ☐ No
Ibuprofen (Advil/Motrin type Generic) Tablet ☐ 200 mg ☐ 400 mg	Pain Reliever / Fever Reducer	☐ Yes ☐ No
Diphenhydramine tablet (Benedryl) or Generic ☐ 25 mg ☐ 50 mg	Hay fever or Upper Respiratory Allergies	☐ Yes ☐ No
Benedryl Cream **OR** Generic	Rashes	☐ Yes ☐ No
Aloe Vera	Minor Burns	☐ Yes ☐ No
Antibiotic Ointment/Cream (Bacitracin, Neosporin) **OR** Generic	Prevent Infection from Minor Scrapes	☐ Yes ☐ No

Over-the-Counter Medication dispensed per package directions:	Indications:	Yes / No
Calamine/Caladryl Lotion	Relief from Itching (Poison Ivy/Insect Bites)	☐ Yes ☐ No
Hydrocortisone Cream **OR** Generic	Rashes	☐ Yes ☐ No
Sterile Eye Drops/Saline Flushing Solution/Visine A **OR** Generic	Eye Irritation / Eye Allergy	☐ Yes ☐ No
Calcium Carbonate Chewable (Tums) or generic	Upset Stomach	☐ Yes ☐ No
Cough Drops/Throat Lozenges	Cough/Throat Irritation	☐ Yes ☐ No
Vaseline	Chapped Lips	☐ Yes ☐ No

Please add other OTC medications you expect to provide for your student.

Do not list prescription medications in this location --- Please complete an Authorization for Prescription Medication form all prescription medication.

Over-the-Counter medication dispensed per package directions:	Indications	Yes	No

I give permission for the medication(s) listed above to be given to my student according to manufacturer label directions and administration by designated personnel as delegated by the school Health Aide.

Parent/Guardian Signature: _____ **Date:** _____

Physician Signature: _____ Telephone #: _____ **Date:** _____