Student Over The Counter Medication Permission Form
Wythe County Public Schools

Student School Name

Grade

Teacher Name

Student Full Name Last, First, Middle

Parent/Legal Guardian Name

Emergency Phone Number
(xxx)-xxx-xxxx

Parent/Legal Guardian Name

Emergency Phone Number
(xxx)-xxx-xxxx

I grant permission for the nurse/principal designee to dispense the following non-prescription medications to my daughter/son.
Please check all that apply.

- ☐ Antacid Tablets
- ☐ Cough Drops
- ☐ Ibuprofen or Motrin
- ☐ Liquid Benadryl
- ☐ Tylenol or Acetaminophen

I grant permission for the nurse/principal designee to use the following first aid products to my daughter/son.
Please check all that apply.

- ☐ Alcohol
- ☐ Aloe Vera
- ☐ Antibiotic Ointment
- ☐ Bacitracin
- ☐ Benadryl Cream
- ☐ Caladryl Cream
- ☐ Carmex
- ☐ Cortisone Cream
- ☐ Eye Wash
- ☐ First Aid Cream
- ☐ Neosporin
- ☐ Orajel
- ☐ Peroxide
- ☐ Sun Screen
- ☐ Vaseline
- ☐ Visine

Prescription medication that is administered at school ***requires a Physician's Signature***, please contact the School Nurse for the necessary ***Student Medication Administration Form***.

Parent/Legal Guardian Printed Name

Parent/Legal Guardian Signature

Date mm/dd/yyyy

Revised 03/2016