PARENTAL AUTHORIZATION FOR USE OF OVER-THE-COUNTER MEDICATION, NOTIFICATION OF CHILD'S ALLERGIES, and CURRENT MEDICATIONS

My child, _____, has no known allergies.

My child, _____, is allergic to the following (e.g., medications, foods, insect bites, etc.):

_____

_____

_____

You have my permission to give my child the following over-the-counter medications, as needed, for ailments such as headache, fever, stomach cramps, sinus congestion, upset stomach, etc. Please check the medications that your child is allowed to have:

_____Benadryl or generic equivalent

_____Ibuprofen (Motrin)

_____Acetaminophen (Tylenol)

_____Neosporin or generic equivalent (topical antibiotic)

_____Pepto-Bismol or generic equivalent

_____Sudafed or available replacement

_____Rolaids or generic equivalent

_____Cough syrup

Comments:

_____

_____

My child is currently taking the following medications. Please list the medications and their purpose.

_____

_____

_____

Signature of Parent/Guardian:_____ Date:_____