Over The Counter Medication Form

For Overnight School Trip

Northmont City Schools
4001 Old Salem Road
Englewood OH 45322

Each chaperone will have a locked medication bag with a supply of acetaminophen, ibuprofen, and antacids.

Name of Student: ______________________________________ Student's birthdate: _______________________

School Building: _________________________ Grade/ Team: ________________ Chaperone: __________________

My child may take the following medication on the trip. I understand that non-medical school personnel may administer these medications. This authorization will be in effect for the current trip unless revoked in writing by the parent/guardian. <u>Bottle directions for age/weight will be followed to determine the dosage</u>.

________ Acetaminophen (325 mg generic Tylenol)

________ Ibuprofen (200 mg)

________ Antacid

________ Antihistamine (25 mg generic Benadryl * Emergency use only *)

____ ___________________________

Parent/Guardian signature Date

___________________________ ___________________________ ___________________________

Cell Phone Daytime Phone Evening Phone

FOR SCHOOL USE: Document in pen: **date, time and initial** when a medication is given. If it wasn't documented, it wasn't done.

Date	Medication	Dose	Time	Reason	Initials

School Employee Signature: _______________________________________

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Additional OTC Medication

Provided by Parent/Guardian

Name of Student: ______________________________________ Student's birthdate: _______________________

School Building: _______________________ Grade/Team: _________________Chaperone: _____________________

My child may take the medication listed below on the trip. I understand that non-medical school personnel may administer this medication. This authorization will be in effect for the current trip unless revoked in writing by the parent/guardian.

As parent/guardian, I have supplied the following over the counter medication for my child to take as needed. I understand that the school district maintains the right to restrict the use of this form for certain over the counter medications. Directions will be followed as directed on the original packaging/bottle to determine dosage.

Name of medication: ____

How much: _______________________ How often: __________________ When: _________________________

____ _____________________________

Parent/Guardian signature Date

____________________________ ____________________________ ____________________________

Cell Phone Daytime Phone Evening Phone

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Date	Medication	Dose	Time	Reason	Initials

School Employee Signature: _______________________________________