



OVER-THE-COUNTER MEDICATION FORM

Student Name: _____ **Weight:** _____

Allergies: _____ **DOB:** _____

MEDICATION	DOSAGE	INDICATION	PARENT INITIAL	PHYSICIAN INITIAL
Acetaminophen/ Tylenol	160mg/5ml liquid	pain/fever		
Acetaminophen/Tylenol	325mg or 500mg tablet	pain/fever		
Calcium Antacid/Tums	chewable tablet	acid indigestion/upset stomach/heartburn		
Cough Drops		cough/throat irritation		
Diphenhydramine/Benadryl	12.5 mg/5ml liquid	allergy/antihistamine		
Diphenhydramine/Benadryl	25 mg tablet/capsule	allergy/antihistamine		
Ibuprofen/Advil	100mg/5ml liquid	pain/fever		
Ibuprofen/Advil	200 mg tablet	pain/fever		
Cetirizine/Zyrtec	1mg/1ml liquid	allergy/antihistamine		
Cetirizine/Zyrtec	5 mg or 10 mg chewable or tablet	allergy/antihistamine		
Loratadine/Claritin	10 mg tablet	allergy/antihistamine		
Hydrocortisone Cream	1%	insect bites hives/itching/swelling		
Refresh Eye Drops	1-2 drops	dry eyes		
Allergy Eye Drops	1-2 drops	itchy, red, dry eyes		

Parent Signature _____ **Date** _____

Physician Signature _____ **Date** _____

I am requesting that BACS employees administer the above medication to my child as needed. I understand medications will only be administered if they are in the original bottle, correctly labeled, and age dose appropriate. I understand that BACS and its employees will not be held liable for any injury or side effects from administration of this medication. I understand that this medication authorization is only valid for one school year.

Parents must provide all medications. The BACS Clinic does not stock or provide any medications. All medication must be kept in the clinic. No self-carry of OTC meds permitted. Dose must be age/weight appropriate and in compliance with package dosing guidelines.