

Student Name: _____ Grade: _____

**GOFFSTOWN HIGH SCHOOL
OVER-THE-COUNTER MEDICATION PERMISSION FORM**

It is the policy of the NH Department of Education that we must have written permission from a child's parent or legal guardian for a child to receive any medication at school. A new form must be completed each school year.

We stock the medications listed below in the GAHS Health Office. Administration is based on assessment of symptoms and in accordance with physician-approved guidelines. Medications are given according to child's weight and age. If your child needs any over-the-counter medication which is not listed below, you will need to provide the Health Office with the medication for the school nurse to dispense. Per school policy, medications must be delivered to the school nurse by parent or legal guardian in the original container and clearly labeled with your child's name. Medication left at the end of the school year must be picked up by parent/legal guardian or it will be disposed of properly.

Please check off the medications listed below that you authorize your child to receive and return this form to GAHS health office. **REMEMBER THAT WE CAN ONLY GIVE MEDICATION WITH WRITTEN PERMISSION!!**

- | | |
|---|--|
| <input type="checkbox"/> Acetaminophen (tylenol) | <input type="checkbox"/> Oragel |
| <input type="checkbox"/> Ibuprofen (advil) | <input type="checkbox"/> Hydrocortisone cream |
| <input type="checkbox"/> Menthol cough drops | <input type="checkbox"/> Calamine Lotion |
| <input type="checkbox"/> Diphenhydramine HCL (benadryl) | <input type="checkbox"/> Aloe Gel |
| <input type="checkbox"/> Pseudoephedrine HCL (sudafed) | <input type="checkbox"/> Antibiotic Ointment |
| <input type="checkbox"/> Calcium antacid tabs (tums) | <input type="checkbox"/> Bactine Spray |
| <input type="checkbox"/> Anesthetic throat spray | <input type="checkbox"/> Mineral Ice gel (menthol) |

** Other Over-the-Counter medication not listed above that will be provided by parent:

Special Instructions: _____

ALLERGIES: _____

I give permission for the school nurse, or designee, to give my child, _____, the medications I have indicated my approval of with a check mark, including the medication I have indicated in "other" selection. If the school nurse feels that my child is requesting this medication too often, I will be notified.

Parent/Guardian Signature _____ Date _____

Name _____ Grade _____

Does your child have any health/medical conditions? Yes ___ No ___

If yes, please indicate:

ADD/ADHD (which) _____

Allergies (list) _____ Mild ___ Severe ___

Asthma ___ Mild ___ Severe ___ Triggers _____

Diabetes ___ Insulin Dependant ___ Oral meds _____

Hearing/Vision Impairment (which) _____

Physical Handicap (describe) _____

Other _____

Is your child taking any prescription medication? ___ yes ___ no

If yes please list _____

Has your child had any immunizations, including tetanus shots, this year?

Please list dates given so their health record may be updated:
