



3470 ROUTE 16, NORTH CONWAY
P.O. BOX 495, INTERVALE, NH 03845
(603) 356-3272 www.mvmontessori.com

Over-the-counter Medication Authorization Form

School personnel are unable to give over-the-counter medication to your child without your written permission. This form will give school staff personnel, who are certified in first aid training, permission to administer the medications checked below to your child when or if your child develops pain or fever at school, has a minor injury, gets an insect bite, etc. School staff personnel are expected to use their first aid knowledge and experience to assess the need for medication. ***It is recommended that you check with your medical provider to make sure there are no contraindications to the medication that you have selected for your child below.*** Notification will be given if any medication is given during the school day.

CHILD'S NAME _____ BIRTHDATE _____ SEX _____

By checking the medications below, I give permission for my child to receive the following during this school year:

- _____ acetaminophen (age/weight appropriate dose)
- _____ ibuprofen (age/weight appropriate dose)
- _____ Benadryl (age/weight appropriate dose for allergic reaction, swelling)
- _____ hydrocortisone cream 0.5% for itching bug bites or small rashes
- _____ antibiotic ointment for minor cuts and abrasions
- _____ SPF 30 sunscreen
- _____ insect repellent

_____ I DO NOT want my child to receive ANY medication at school unless I specifically provide it to the school for my child's use.

I authorize the school to assist my child in taking the medications indicated above, as needed, during school hours. I agree that I will not hold liable any member of the school staff for administering said medications according to package directions to my child.

Parent or Guardian Signature

Date

updated

initials

updated

initials

updated

initials