

Boston Public Schools – Consent for Administration of Approved OTC Medications

Date: / /

Is your child allergic or sensitive to any medications? If yes, which ones? _____

Any medical or health problems? ☐ No ☐ Yes - Please explain:

List any long-term medication your child receives: _____

I give permission for my child _____ to receive the medication(s) listed/checked below as deemed necessary by the School Nurse. I understand that a generic equivalent medication may be used. I understand that **Only the School Nurse**, in accordance with established written protocols, will administer the medication(s) I have checked. Please contact the School Nurse with any questions or concerns.

- ☐ Ibuprofen (Advil, Motrin)
- ☐ Acetaminophen (Tylenol)
- ☐ Bacitracin (or other antibacterial cream/ointment)
- ☐ Calamine Lotion / other topical

Signature of Parent/Guardian

 / /
Date

Home Phone

Cell Phone

Work Phone

Emergency Phone