Student Name: **D.O.B:** **GRADE:**

Consent for Over the Counter (OTC) Medications 2015-2016: Please √ if you would like your son to receive any over-the-counter medicines in school. If so, please indicate what medicines the nurse can administer to your son. The appropriate dose will be administered as indicated unless otherwise specified by the physician/nurse practitioner**.** ***Parent and physician must sign this form to be valid.***

_____I hereby give permission for my son to receive the medications checked below as deemed necessary by the school nurse or designated personnel in accordance with established protocols.

_____I **DO NOT** want any medication given to my son in school.

Parent Signature: ____ Date: ____________

Physician Signature: ______________________________________Date: ____________

____Ibuprofen, 400 mg	____Cough Medicine
____Tylenol, 1000 mg	____Cough Drops
____Benadryl	____Pepto-Bismol
____Loratadine Allergy Relief	____Antacid Tablets
____Decongestant	____Antibiotic Ointment
____Cepacol Sore Throat Lozenges	____Hydrocortisone Cream 1%

Please return form to: Mount Saint Joseph High School
Attention: Health Room
4403 Frederick Avenue
Baltimore, MD 21229