Cincinnati Classical Academy

Over The Counter Medication Authorization Form

Student Information

Student Name & Address	DOB	Student Allergies

Medication Information

Medications Authorized			Authorization Duration
☐ Ibuprofen	☐ Neosporin	☐ Benadryl Cream	☐ Entirety of attendance (*all years*)
☐ Acetaminophen	☐ TUMS	☐ Hydrocortisone Cream	☐ Custom End Date of:
☐ Antihistamine	☐ Cough Drops	☐ Other: ________________	______/____/______

Authorization Information

By signing this form, we understand and agree to the following:

- We have determined that the administration of the OTC medications selected above are advisable and safe for my child.
- We understand any instructions to administer an OTC medication in a manner inconsistent with the manufacturer's recommended instructions must be ordered by a physician. A copy of the physician's prescription/instructions will be required prior to administration.
- We hereby give permission for the school to give the OTC medication to my child according to the directions on the package.
- We take full responsibility for any adverse effects of such medication administration.
- We also agree to notify the school in writing of the termination of this request or when any change in the above orders is necessary.
- We further understand that this consent is only valid for the specific medications listed above for the duration listed above.
- We agree to release and hold the school and their respective employees harmless from and against all claims arising from the administration of the medications selected by the school.

Parent Signature: ______________________________ **Phone #:** ____________________ **Date:** ______________