Standing Order Form for Over-the-Counter Medications

Student Name: _____ **Allergies:** _____

_____ I do not want any over-the-counter medications given to my child.

As the parent/guardian for the above named person, I hereby give my approval for the administration or self - administration of the following medications as they are deemed necessary. Unless otherwise noted, the dosage will be the normal adult dosage per package directions. If symptoms continue, or the person's condition deteriorates, he or she will be taken to a physician or ER to be assessed.

	Yes	No
Pain		
Acetaminophen (Tylenol)		
Ibuprofen (Advil)		
Midol		
Aleve		
Cold/Sinus		
Cold and Allergy Syrup		
Decongestant (e.g. Sudafed)		
Tussin Expectorant		
Cough Drops		
Afrin		
Benadryl		
Zyrtec or Claritin		
Mucus Relief (Guafenesin)		
Eyes/Ears		
Artificial Tears		
Saline eye drops		

	Yes	No
Digestive Aids		
Pepto Bismol		
Immodium (Anti-diarrheal)		
Tagamet / Zantac (Acid Reducer)		
Prilosec		
Gas Relief		
Tums		
Skin Care		
Triple antibiotic ointment		
A&D Ointment		
Hydrocortisone Cream		
Antifungal /Athletes Foot Cream		
Other		
Motion Sickness Relief		
Anti-Nausea Liquids		
Aspirin		
Absorbine Jr.		
Muscle Rub Cream		

List prescription medications that student has permission to use (including inhalers):

_____

_____

Parent Signature _____ **Date:** _____