FROM THE SCHOOL NURSES

Dear Parents:

The policy for over the counter (OTC) medication administration in the health room has been updated according to the standards that are mandated by the Howard County Health Department and the Nurse Practice Act of Maryland. In the past we have dispensed OTC medications with only the parent's written or verbal permission. **We are no longer able to dispense over the counter medications without the written consent of the parent and the student's physician.** There will be no exceptions. Attached is an Over the Counter (OTC) form that gives permission from both you and your child's doctor to us to administer OTC medicines which will be available to the students for occasional symptoms. You will be notified if your child receives an OTC medicine in the health room.

The policy for Prescription medications remains the same. Prescription medications that need to be given to the student during the school day must be accompanied by a signed Medication Order Form from the prescribing physician and be in the original container (your pharmacist will give you a second labeled container for school use if you request it). Because of possible reactions to medication you must give the **first** dose of any new prescription or OTC medication at home, except for "as needed" (PRN) emergency meds for allergies. Parents/guardians must deliver medicine to the Health Room. **Students are not permitted to transport medications to the Health Room.**

We appreciate your cooperation and ask that you call if you have any questions regarding any aspect of these policies. They are designed with the best interests of our students in mind. We look forward to a happy and healthy year for all.

Sincerely,

Mrs. Gough, RN and Mrs. Miranda, RN
School Nurses

CONSENT FOR ADMINISTRATION OF OVER THE COUNTER MEDICATIONS

Student's Name: _____ Grade: _____ School Year_____

Known Allergies_____

List any long-term medications now receiving_____

Check the over-the -counter medications listed below that you wish available to your child in School. Please indicate dosage if applicable.

Check if yes	Medication		
_____	Advil (Ibuprofen)	**Under 12yrs**, 5mg/kg P.O. q6-8 hrs prn, **12 yrs or older**, 200-400mg P.O. q4-6 hrs prn	
_____	Tylenol (Acetaminophen)	**Under 12 years**, 10mg/kg P.O. q4-6hrs prn **12 yrs or older**, 650-1000mg P.O. q4-6hrs prn	
_____	Benadryl (Diphenhydramine)	**6-12 yrs**, 12.5-25 mg P.O. q4-6hrs prn **12 yrs or older**, 25-25mg P.O. q4-6hrs prn	
_____	Antacid tablet (Tums)	_____	Anti-itch lotion/cream (Calamine)
_____	Anti-itch gel (Benadryl)	_____	Antibiotic Ointment
_____	Cough drops	_____	Other: _____
_____	Sunscreen/sun block		

_____ I do **NOT** want any medication given to my child in school

_____	_____	_____	_____
Parent/Guardian Signature	Date	Home Phone	Work Phone
_____	_____	_____	_____
Physician's Signature	Date	Office Phone	Fax